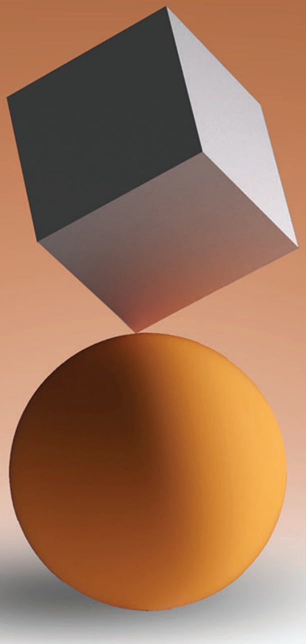
CLINICAL HANDBOOK OF COUPLE THERAPY

SIXTH EDITION



edited by Jay L. Lebow and Douglas K. Snyder

GUILFORD PRESS
e-book

CLINICAL HANDBOOK OF COUPLE THERAPY

Also from Jay L. Lebow and Douglas K. Snyder

FOR PROFESSIONALS

Common Factors in Couple and Family Therapy:
The Overlooked Foundation for Effective Practice
Douglas H. Sprenkle, Sean D. Davis, and Jay L. Lebow

Couple-Based Interventions for Military and Veteran Families:
A Practitioner's Guide
Edited by Douglas K. Snyder and Candice M. Monson

Helping Couples Get Past the Affair: A Clinician's Guide
Donald H. Baucom, Douglas K. Snyder, and Kristina Coop Gordon

Treating Difficult Couples: Helping Clients
with Coexisting Mental and Relationship Disorders
Edited by Douglas K. Snyder and Mark A. Whisman

FOR GENERAL READERS

Getting Past the Affair: A Program to Help You Cope,
Heal, and Move On—Together or Apart
Douglas K. Snyder, Donald H. Baucom, and Kristina Coop Gordon

CLINICAL HANDBOOK OF COUPLE THERAPY

SIXTH EDITION

edited by

Jay L. Lebow

Douglas K. Snyder

THE GUILFORD PRESS
New York London

Copyright © 2023 The Guilford Press
A Division of Guilford Publications, Inc.
370 Seventh Avenue, Suite 1200, New York, NY 10001
www.guilford.com

All rights reserved

No part of this book may be reproduced, translated, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, microfilming, recording, or otherwise, without written permission from the publisher.

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards of practice that are accepted at the time of publication. However, in view of the possibility of human error or changes in behavioral, mental health, or medical sciences, neither the authors, nor the editors and publisher, nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or the results obtained from the use of such information. Readers are encouraged to confirm the information contained in this book with other sources.

Library of Congress Cataloging-in-Publication Data
Names: Lebow, Jay, editor. | Snyder, Douglas K., editor.
Title: Clinical handbook of couple therapy / edited by Jay L. Lebow, Douglas K. Snyder.
Description: Sixth edition. | New York, NY : The Guilford Press, [2023] | Includes bibliographical references and index.
Identifiers: LCCN 2022001583 | ISBN 9781462550128 (cloth)
Subjects: LCSH: Marital psychotherapy—Handbooks, manuals, etc.
Classification: LCC RC488.5 .C584 2022 | DDC 616.89/1562—dc23
LC record available at https://lccn.loc.gov/2022001583

Editors' note. The case illustrations in this book are based on the authors' research and clinical practice. In all instances, names and identifying information have been changed.

To our friends, colleagues, and precious loved ones
who have encouraged and sustained us over the years.
From the depth of our hearts—we thank you.

About the Editors

Jay L. Lebow, PhD, ABPP, LMFT, is Clinical Professor of Psychology at Northwestern University and Senior Scholar at The Family Institute at Northwestern. He is also editor-in-chief of the journal *Family Process*. Dr. Lebow has engaged in clinical practice, supervision, and research on couple and family therapy since the 1970s, and is board certified in family psychology and an approved supervisor and clinical fellow of the American Association for Marriage and Family Therapy (AAMFT). His numerous publications focus on the practice of couple and family therapy, the relationship of research and practice, integrative practice, and intervention strategies with divorcing families. Dr. Lebow served as president of Division 43 (Society for Couple and Family Psychology) of the American Psychological Association (APA) and on the board of directors of the American Family Therapy Academy (AFTA). He is a recipient of the Lifetime Achievement Award from AFTA and the Family Psychologist of the Year Award from Division 43 of APA.

Douglas K. Snyder, PhD, is Professor of Psychological and Brain Sciences at Texas A&M University, where he also served as Director of Clinical Training for 20 years. Dr. Snyder has engaged in clinical practice and training of couple therapists since the 1970s, and is a clinical member of AAMFT. He is coauthor or coeditor of several books, including *Helping Couples Get Past the Affair* and *Couple-Based Interventions for Military and Veteran Families*. Dr. Snyder has served as editor of the *Clinician's Research Digest* and as associate editor of the *Journal of Consulting and Clinical Psychology* and the *Journal of Family Psychology*. He is a recipient of the Distinguished Contribution to Research in Family Therapy Award from AAMFT, the Distinguished Contribution to Family Psychology Award from Division 43 of APA, and the Distinguished Psychologist Award from Division 29 (Society for the Advancement of Psychotherapy) of APA.

Contributors

Robert Allan, PhD, School of Education and Human Development, University of Colorado Denver, Denver, Colorado

Samuel H. Allen, PhD, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Christina Balderrama-Durbin, PhD, Department of Psychology, Binghamton University, State University of New York, Binghamton, New York

Donald H. Baucom, PhD, Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Steven R. H. Beach, PhD, Center for Family Research and Department of Psychology, University of Georgia, Athens, Georgia

Efrain Bleiberg, MD, The Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, Texas

Kristin Bolton, PhD, School of Social Work, University of North Carolina Wilmington, Wilmington, North Carolina

Douglas C. Breunlin, MSSA, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Will H. Canu, PhD, Department of Psychology, Appalachian State University, Boone, North Carolina

Ryan G. Carlson, PhD, Department of Educational Studies, University of South Carolina, Columbia, South Carolina

Anthony L. Chambers, PhD, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Andrew Christensen, PhD, Department of Psychology, University of California, Los Angeles, Los Angeles, California

Aaron Samuel Cohn, PhD, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Gene Combs, MD, Evanston Family Therapy Center, Evanston, Illinois

Deb Coolhart, PhD, Marriage and Family Therapy Department, Syracuse University, Syracuse, New York

Joanne Davila, PhD, Department of Psychology, Stony Brook University, Stony Brook, New York

Sean Davis, PhD, California School of Professional Psychology, Alliant International University, Sacramento, California

Sona Dimidjian, PhD, Crown Institute and Department of Psychology and Neuroscience, University of Colorado Boulder, Boulder, Colorado

Brian D. Doss, PhD, Department of Psychology, University of Miami, Miami, Florida

Elizabeth E. Epstein, PhD, Department of Psychiatry, University of Massachusetts Chan Medical School, Worcester, Massachusetts

Norman B. Epstein, PhD, Department of Family Science, School of Public Health, University of Maryland, College Park, Maryland

Melanie S. Fischer, PhD, Department of Psychology, Philipps-Universität Marburg, Marburg, Germany

Mona DeKoven Fishbane, PhD, Chicago Center for Family Health, Chicago, Illinois

Peter Fonagy, PhD, Research Department of Clinical, Educational, and Health Psychology, University College London, London, United Kingdom

Peter Fraenkel, PhD, Department of Psychology, The City College of New York, New York, New York

Cynthia Franklin, PhD, Steve Hicks School of Social Work, The University of Texas at Austin, Austin, Texas

Steffany J. Fredman, PhD, Department of Human Development and Family Studies, The Pennsylvania State University, University Park, Pennsylvania

Jill Freedman, MSW, Evanston Family Therapy Center, Evanston, Illinois

Elana B. Gordis, PhD, Department of Psychology, University at Albany, State University of New York, Albany, New York

Kristina Coop Gordon, PhD, Department of Psychology, University of Tennessee, Knoxville, Tennessee

John Mordechai Gottman, PhD, The Gottman Institute, Seattle, Washington

Julie Schwartz Gottman, PhD, The Gottman Institute, Seattle, Washington

Kathryn S. K. Hall, PhD, private practice, Princeton, New Jersey

Cathryn Glanton Holzhauer, PhD, VA Central Western Massachusetts Healthcare System and Department of Psychiatry, University of Massachusetts Chan Medical School, Worcester, Massachusetts

Sabrina Johnson, EdS, Department of Educational Studies, University of South Carolina, Columbia, South Carolina

Susan M. Johnson, EdD, International Centre for Excellence in Emotionally Focused Therapy, University of Ottawa, Ottawa, Ontario, Canada

Lana Kim, PhD, Graduate School of Education and Counseling, Lewis & Clark College, Portland, Oregon

Jennifer S. Kirby, PhD, Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Bob G. Knight, PhD, School of Psychology and Counselling, University of Southern Queensland, Toowoomba, Queensland, Australia

Kayla C. Knopp, PhD, VA San Diego Healthcare System and Department of Psychiatry, University of California, San Diego, La Jolla, California

Carmen Knudson-Martin, PhD, Graduate School of Education and Counseling, Lewis & Clark College, Portland, Oregon

Jaslean J. LaTaillade, PhD, JBS International, Inc., North Bethesda, Maryland

Erika Lawrence, PhD, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Jay L. Lebow, PhD, ABPP, LMFT, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Gayla Margolin, PhD, Department of Psychology, University of Southern California, Los Angeles, California

Howard J. Markman, PhD, Department of Psychology, University of Denver, Denver, Colorado

Christopher R. Martell, PhD, Psychological Services Center, University of Massachusetts Amherst, Amherst, Massachusetts

Barbara S. McCrady, PhD, Center on Alcohol, Substance Use, and Addictions and Department of Psychology, University of New Mexico, Albuquerque, New Mexico

Susan H. McDaniel, PhD, Departments of Psychiatry and Family Medicine, University of Rochester, Rochester, New York

Erica A. Mitchell, PhD, College of Education, Health, and Human Sciences, University of Tennessee, Knoxville, Tennessee

Candice M. Monson, PhD, Department of Psychology, Toronto Metropolitan University, Toronto, Ontario, Canada

Leslie A. Morland, PsyD, VA San Diego Healthcare System and Department of Psychiatry, University of California, San Diego, La Jolla, California

Patricia L. Papernow, EdD, Institute for Stepfamily Education, Hudson, Massachusetts

Hannah F. Rasmussen, MA, Department of Psychology, University of Southern California, Los Angeles, California

Galena K. Rhoades, PhD, Department of Psychology, University of Denver, Denver, Colorado

Nancy Breen Ruddy, PhD, Department of Clinical Psychology, Antioch University New England, Keene, New Hampshire

William P. Russell, MSW, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Ellen Safier, LCSW, The Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, Texas

Judith P. Siegel, PhD (retired), Silver School of Social Work, New York University, New York, New York

Douglas K. Snyder, PhD, Department of Psychological and Brain Sciences, Texas A&M University, College Station, Texas

Alexandra H. Solomon, PhD, The Family Institute at Northwestern, Northwestern University, Evanston, Illinois

Scott M. Stanley, PhD, Department of Psychology, University of Denver, Denver, Colorado

Daniel N. Watter, EdD, Morris Psychological Group, Parsippany, New Jersey

Carol A. Werlinich, PhD, private practice, Dayton, Maryland

Mark A. Whisman, PhD, Department of Psychology and Neuroscience, University of Colorado Boulder, Boulder, Colorado

Stephanie A. Wiebe, PhD, School of Counselling, Psychotherapy, and Spirituality, Saint Paul University, Ottawa, Ontario, Canada

Elizabeth R. Wrape, PhD, VA San Diego Healthcare System and Department of Psychiatry, University of California, San Diego, La Jolla, California

Brian T. Wymbs, PhD, Department of Psychology, Ohio University, Athens, Ohio

Frances A. Wymbs, PhD, Department of Primary Care, Ohio University, Athens, Ohio

Helen Taylor Yates, PhD, School of Social Work, University of North Carolina Wilmington, Wilmington, North Carolina

Anao Zhang, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Contents

PART I. OVERVIEW AND GUIDING PRINCIPLES

CHAPTER 1 Couple Therapy in the 21st Century 3
Jay L. Lebow and Douglas K. Snyder

CHAPTER 2 Couple Assessment 22
Douglas K. Snyder and Christina Balderrama-Durbin

PART II. MODELS OF COUPLE THERAPY

BEHAVIORAL APPROACHES

CHAPTER 3 Cognitive-Behavioral Couple Therapy 53
Donald H. Baucom, Norman B. Epstein, Melanie S. Fischer, Jennifer S. Kirby, and Jaslean J. LaTaillade

CHAPTER 4 Integrative Behavioral Couple Therapy 79
Andrew Christensen, Sona Dimidjian, Christopher R. Martell, and Brian D. Doss

CHAPTER 5 Acceptance and Commitment Therapy for Couples 104
Erika Lawrence, Aaron Samuel Cohn, and Samuel H. Allen

EMOTION-CENTERED, PSYCHODYNAMIC, AND MULTIGENERATIONAL APPROACHES

CHAPTER 6 Emotionally Focused Couple Therapy 127
Susan M. Johnson, Stephanie A. Wiebe, and Robert Allan

CHAPTER 7 Object Relations Couple Therapy 151
Judith P. Siegel

CHAPTER 8 Mentalization-Based Couple Therapy 175
Efrain Bleiberg, Ellen Safier, and Peter Fonagy

CHAPTER 9 Intergenerational Factors in Couple Therapy 199
Mona DeKoven Fishbane

POSTSTRUCTURAL APPROACHES

CHAPTER 10 Narrative Couple Therapy 227
Jill Freedman and Gene Combs

CHAPTER 11 Solution-Focused Couple Therapy 250
Cynthia Franklin, Anao Zhang, Kristin Bolton, and Helen Taylor Yates

CHAPTER 12 Socioculturally Attuned Couple Therapy 267
Carmen Knudson-Martin and Lana Kim

INTEGRATIVE APPROACHES

CHAPTER 13 Common Factors in Couple Therapy 295
Sean Davis

CHAPTER 14 Integrative Systemic Therapy for Couples 318
Douglas C. Breunlin, William P. Russell, Anthony L. Chambers, and Alexandra H. Solomon

CHAPTER 15 Therapeutic Palette Integrative Couple Therapy 339
Peter Fraenkel

CHAPTER 16 Gottman Method Couple Therapy 362
John Mordechai Gottman and Julie Schwartz Gottman

PART III. APPLICATIONS OF COUPLE THERAPY

SPECIFIC RELATIONAL ISSUES AND POPULATIONS

CHAPTER 17 Couple Therapy for Partner Aggression 391
Norman B. Epstein, Jaslean J. LaTaillade, and Carol A. Werlinich

CHAPTER 18 Couple Therapy for Infidelity 413
Kristina Coop Gordon, Erica A. Mitchell, Donald H. Baucom, and Douglas K. Snyder

CHAPTER 19 Couple Therapy and Sexuality 434
Kathryn S. K. Hall and Daniel N. Watter

CHAPTER 20 Therapy with Older Adult Couples 454
Bob G. Knight

CHAPTER 21 Divorce Issues in Couple Therapy 472
Jay L. Lebow

CHAPTER 22 Therapy with Stepfamily Couples 492
Patricia L. Papernow

CHAPTER 23 Therapy with Queer Couples 512
Deb Coolhart

COUPLE-BASED THERAPY FOR INDIVIDUAL PROBLEMS

CHAPTER 24 Couple Therapy for Posttraumatic Stress Disorder 533
Candice M. Monson and Steffany J. Fredman

CHAPTER 25 Couple Therapy for Alcohol Problems 554
Barbara S. McCrady, Elizabeth E. Epstein, and Cathryn Glanton Holzhauer

CHAPTER 26 Couple Therapy for Depression or Anxiety 576
Mark A. Whisman, Steven R. H. Beach, and Joanne Davila

CHAPTER 27 Couple Therapy with Parents of Youth with Attention-Deficit/Hyperactivity Disorder or Disruptive Behavior Disorders 595
Frances A. Wymbs, Brian T. Wymbs, and Will H. Canu

CHAPTER 28 Couple Therapy and Medical Issues 615
Nancy Breen Ruddy and Susan H. McDaniel

SPECIAL TOPICS

CHAPTER 29 Relationship Enhancement and Distress Prevention 639
Ryan G. Carlson, Galena K. Rhoades, Sabrina Johnson, Scott M. Stanley, and Howard J. Markman

CHAPTER 30 Telehealth and Digital Couple Interventions 656
Brian D. Doss, Kayla C. Knopp, Elizabeth R. Wrape, and Leslie A. Morland

CHAPTER 31 Ethical Issues in Couple Therapy 677
Gayla Margolin, Elana B. Gordis, and Hannah F. Rasmussen

Index 699

PART I

OVERVIEW AND GUIDING PRINCIPLES

CHAPTER 1

Couple Therapy in the 21st Century

Jay L. Lebow and Douglas K. Snyder

Couple therapy is an evolving field, and this *Handbook*, now in its sixth edition, reflects this evolution. One transcendent fact is apparent in even a cursory examination of the contents of the current edition: Couple therapy is now an important, widely disseminated form of therapy. There was a time when couple therapy was treated as an afterthought in considerations of psychotherapy and counseling, and seen as consisting of methods derived from individual or family therapy. Today, couple therapy has emerged as a form of treatment that stands on its own, is widely practiced, and has its own distinct methods. The largest international study of psychotherapists found that 70% of psychotherapists treat couples (Orlinsky & Ronnestad, 2005). A survey of expert psychotherapists' predictions about future practices in psychotherapy showed couple therapy to be the format likely to achieve the most growth in the next decade (Norcross, Pfund, & Prochaska, 2013).

Two key factors have driven the development and widespread adoption of couple therapy as a prominent therapeutic modality: the high prevalence of couple distress, and its adverse impact on the emotional and physical well-being of adult partners and their offspring. In the United States, 40–50% of first marriages end in divorce (Kreider & Ellis, 2011). Globally, across almost all countries for which data are available, divorce rates increased from the 1970s to the beginning of this century (Organization of Economic Cooperation and Development, 2011). Independent of divorce, many couple relationships experience periods of significant turmoil that place partners at risk for developing symptoms of various emotional or physical health disorders. In a U.S. survey, the most frequently cited causes of acute emotional distress were couple relationship problems (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). Partners in a distressed relationship are significantly more likely to have a mood disorder, anxiety disorder, or substance use disorder (McShall & Johnson, 2015) and to develop more physical health problems (Waite & Gallagher, 2000). Moreover, couple distress has been related to a wide range of deleterious effects on children, including mental and physical health problems, poor academic performance, and a variety of other concerns (Bernet, Wamboldt, & Narrow, 2016).

Many widely embraced principles of couple therapy have emerged that transcend theoretical orientation, as well as several widely disseminated specific approaches to couple therapy aimed at reducing couple distress and improving relationship quality. Additional couple-based interventions have been developed targeting specific couple or individual problems (e.g., infidelity, partner aggression, mental health disorders) and populations (e.g., older adults, stepfamily couples). Although there remain threads of both theoretical and technical connection to various methods of individual and family therapy (Lebow, 2014), the field now features a distinct set of prominent approaches, builds on a large body of basic research focused on intimate relationships, and offers a substantial body of empirical evidence supporting the efficacy and effectiveness of its methods. It has become abundantly clear that effective intervention with couples requires its own set of theories, approaches, and methods anchored in relational science. Furthermore, effective intervention for any psychological problem should include couple-based methods in the therapeutic arsenal.

A BRIEF HISTORY OF COUPLE THERAPY

Gurman and Fraenkel (2002) described four stages in the development of couple therapy. In the early 20th century, an atheoretical marriage counseling emerged, consisting of a pragmatic mix of psychoeducation and advice giving. During this period, most of those working with couples did not label themselves as psychotherapists; often they did not see spouses together. The second phase that began in the 1930s built on expanding the then predominant form of therapy, psychoanalytic psychotherapy, to work with couples. Initially, in this treatment, partners tended to be seen separately by the same therapist in what was called concurrent therapy, but eventually this approach segued into the beginnings of conjoint therapies in which both spouses participated in sessions. Nonetheless, Michaelson (1963) estimated that in the 1940s, only 5% of couples experienced counseling conjointly; by the mid-1960s, this number had increased only to about 15%. Phase 3 was sparked by the impact of the family therapy revolution in the 1960s and 1970s, in which prominent models of therapy emerged based in systems theory. Subvariations of such core family systems therapies as experiential, strategic, psychoanalytic, and behavioral therapies focused on couples and couple therapy (Gurman & Kniskern, 1981). These therapies almost invariably saw partners conjointly. In its current phase, couple therapy has emerged as a mature discipline that includes a wide array of distinct treatments, a well-established underlying set of theoretical percepts, a stronger evidence base both in the efficacy of therapies and in its foundation in the emerging body of relational science, and an expanded conceptual framework that includes feminism and multiculturalism, and thus speaks to a broader diversity of couples. This era also includes the flourishing of numerous integrative methods and the development of couple therapy as a format for treating problems of individual partners.

COUPLE THERAPY WORKS

Previous reviews affirm the effectiveness of couple therapy in reducing relationship distress (Bradbury & Bodenmann, 2020; Doss, Roddy, Wiebe, & Johnson, 2022; Lebow, Chambers, Christensen, & Johnson, 2012; Roddy, Walsh, Rothman, Hatch, & Doss, 2020; Shadish & Baldwin, 2003). The average person receiving couple therapy is better off at termination than 70–80% of individuals not receiving treatment—an improvement rate that rivals or exceeds the most effective psychosocial and pharmacological interventions for individual mental health disorders. A variety of couple treatments have also garnered evidence supporting their effectiveness for specific relationship problems including sexual difficulties, infidelity, and intimate partner violence.

Separate from reducing either general or specific relationship difficulties, evidence from clinical trials supports the impact of couple therapies for coexisting emotional, behavioral, and physical health concerns (Fischer, Baucom, & Cohen, 2016; Goger & Weersing, 2022; Hogue, Schumm, MacLean, & Bobek, 2022). For example, chapters included in this *Handbook* describe evidence supporting couple-based interventions for depression or anxiety, posttraumatic stress, and alcohol problems of an adult partner, as well as couple interventions with parents of youth with attention-deficit/hyperactivity disorder (ADHD) or related disruptive behavior disorders. Couple-based interventions for physical health problems constitute a rapidly expanding application—with evidence supporting the benefits of couple therapy for a broad spectrum of conditions including cancer, chronic pain, cardiovascular disease, anorexia nervosa, or type 2 diabetes (Shields, Finley, Chawla, & Meadors, 2012). Common components of couple-based interventions for individual mental and physical health problems emphasize partner support, improved communication, and increased attention to the disorder's adverse impact on the couple relationship. The extension of couple-based treatments to individual disorders reflects one of the most important developments of couple therapy in this century.

A VIEW OF COUPLE THERAPY TODAY

Editing this *Handbook* has been a privilege. Since the inaugural volume edited by Neil Jacobson and Alan Gurman (Jacobson & Gurman, 1986), it has long been a definitive guide to the couple therapy of the time. Over the past 40 years, authors of chapters in this *Handbook* have been a "who's who" in the field of couple therapy, and the approaches covered have provided a snapshot into the *Zeitgeist* of couple therapy at the time of each edition. In this first chapter, we look to extrapolate from the various chapters in this sixth edition to discern broad trends in the field since the prior edition. Moving beyond the obvious observation that this *Handbook* offers a rich and effective set of approaches, we look to articulate general trends in the field, as well as commonalities and continuing major points of difference and controversy across approaches. As we have read the various chapters in this edition, clear trends have emerged. So, in looking at the approaches in this book, what then can we say of couple therapy?

Foundation in Relational Science

One aspect of contemporary couple therapy is its strong foundation in relational science. Bear in mind that couple therapy began as a method of practice before there was a field of relational science. Indeed, at the time of its origin, there were only the most primitive beginnings of social psychology. The infusion of relational science into practice has been slow and evolving.

The first widely recognized connections to science came in the form of bringing outcome and efficacy assessments to couple therapies (Gurman & Kniskern, 1981). To no great surprise, those efforts initially instigated considerable reactivity from those who practiced therapies less frequently represented in the research (Gurman & Kniskern, 1978). Today, the crucial role of evidence in relation to the impact of various couple therapies is widely acknowledged. Most couple therapy begins with the clear purpose of reducing relationship distress and promoting couple wellbeing, measurable outcomes that readily can be compared to the limited changes in relational satisfaction typical of those couples in no-treatment control conditions (Baucom, Hahlweg, & Kuschel, 2003; Roddy et al., 2020).

To some extent, couple therapy has become more firmly established because both meta-analytic data and systematic reviews of the literature affirm the considerable broad impact of couple therapy (Bradbury & Bodenmann, 2020; Doss et al., 2022; Roddy et al., 2020; Shadish & Baldwin, 2003, 2005) and of several of its specific approaches (Fischer et al., 2016; Roddy, Nowlan, Doss, & Christensen, 2016; Wiebe & Johnson, 2016). This research also highlights the impact of couple therapy on individual functioning even when relational functioning is the primary focus of the couple therapy. Moreover, unlike spontaneous remission of some disorders in the absence of treatment, research shows little improvement in relationship satisfaction among distressed couples who do not receive therapy. Care delivery systems find links of couple-based treatments to such clear and measurable outcomes essential.

Even more impactful has been the influence of basic relational science research on couple therapy. Whereas early couple therapy only drew in limited ways on the newly emerging field of relational science, most approaches now cite such basic research as part of the foundation for their methods, be that research about attachment, behavior exchanges, emotion, or characteristics of couples with specific problems or from specific populations. The linkages between basic research and practice articulated by John Gottman (see Gottman & Gottman, Chapter 16) in the late 20th century modeled for others the incorporation of such basic science research into practice. After the emergence of science-based couple therapies, those who promoted their ideas about relationships without providing empirical support, even if remaining fashionable in the popular media, came to have less credibility or influence among researchers and clinicians, who increasingly became committed to effective, evidence-based clinical practice. Moreover, with empirical investigation also came the ability to disconfirm theories and even identify the potential harmful effects of certain untested ideas (Lilienfeld, 2007).

Links to Neuroscience

Closely connected to the incorporation of relational science in practice has been the rapid advance in the integration of relational neuroscience in contemporary approaches. Most models of couple therapy were well developed before the technology was available to assess brain function in relational life. However, in the few years since the publication of the fifth edition of this *Handbook*, there has been an explosion in the information available from neuroscience in relation to couple functioning. Today's couple therapies have begun to incorporate this emerging and exciting new knowledge base. Yet, here there is a caveat. Relational neuroscience is in its infancy. Studies are complex, with endless possible neurotransmitters and brain structures that may be simultaneously influencing and influenced by couple processes. Methodologies range from those using simple, readily available instruments such as pulse oximeters (an inexpensive instrument that has utility here) to very expensive functional magnetic resonance imaging (fMRI) scanners. In exploring the literature and evaluating claims made of findings' implications for clinical practice, the reader needs to remain mindful that a specific finding that supports one approach might also support another, that research findings require replication, that correlation is not causation, and that the body of findings is only just beginning to produce an evidence-based set of knowledge that is widely accepted.

A Convergence of Methods

Upon examining chapters in Part I of this *Handbook* describing various models of couple therapy, we discern an emerging and substantial convergence of methods across different approaches.

Couple Therapy Is Both Pluralistic and Integrative

Contemporary couple therapies often cross the boundaries of schools of therapy and theoretical constructs that typically have been identified in individual therapy and earlier iterations of couple therapy. Thus, for example, while psychoanalytic individual therapy almost exclusively focuses on factors such as transference, the impact of early experience and inner life, the couple therapy variations of these approaches have come to include many other elements such as communication skills building. Similarly, cognitive-behavioral couple approaches today transcend simply focusing on cognitions and behavioral sequences, instead also tapping emotion, meaning, and early experience. Such integration results from a cross-pollination across the couple therapies (wise ideas become assimilated into other models) and the powerful pragmatic issues that every couple therapist faces regardless of orientation, such as how to manage spiraling angry interactions, engage the less invested partner in therapy, promote positive connection, or deal with comorbid individual emotional or physical health concerns.

Most approaches build from a biopsychosocial foundation that includes diverse aspects such as cognition, emotion, the influence of history, and inner psychological processes. Thus, they tap into multiple levels of human experience (Lebow, 2014). For example, Gottman method therapy addresses the direct behavioral level of exchanges and a far deeper level of meaning. Emotionally focused therapy addresses not only underlying primary and derivative emotions but also attachment. Enhanced cognitive-behavioral therapy addresses not only behavioral patterns but also relational schemas and emotion. Integrative systemic therapy addresses the many levels of human experience, from behavioral exchange to inner experience.

Approaches certainly have differences in how much they emphasize each component, but the overlap is considerable. Indeed, in editing this book, we prompted authors to write less about those aspects of their approaches that were drawn from other approaches, so that better conceptual clarity between the essence of schools of couple therapy might be highlighted. Some authors explicitly speak of their approaches as integrative, while others do not; but regardless of whether they do so explicitly, integrative elements frequently permeate.

How should couple therapists think about and make use of these trends toward an expansion of both the specific phenomena to which contemporary approaches attend and the broadening of various theoretical frameworks from which these phenomena are conceptualized? One approach that emerged during the 1970s was eclecticism—defined as the borrowing of specific techniques or constructs without allegiance (or even regard) for the theoretical framework in which those techniques or constructs were originally embedded (Lazarus, 1989). However, risks of eclecticism include the unsystematic or contradictory use of specific interventions, as well as the dismantling of interventions that rely on the synergistic effects of specific components implemented in combination for their effectiveness.

An alternative to eclecticism is pluralism—an approach that recognizes the validity and usefulness of multiple theoretical perspectives and draws on constructs and intervention strategies from across theoretical models by tailoring intervention strategies to a given case at any given moment based on their clinical relevance and potential utility. Pluralism differs from eclecticism in that interventions are always conceptualized from within a theoretical framework. Snyder (1999) advocated a pluralistic approach to couple therapy involving six levels progressing from a foundation of the collaborative alliance and managing initial crises, through strengthening the couple dyad and promoting relevant relationship skills, to addressing cognitive components and developmental sources of relationship distress. The therapeutic palette method of couple therapy presented by Fraenkel (see Chapter 15) articulates a particularly elegant approach to pluralistic practice.

By the 1990s, the majority of therapists self-identified as "integrative" rather than "eclectic" (even if their understanding of the difference might have been limited) (Lebow, 1997). Integration extends beyond pluralism via its blending of theoretical constructs or therapeutic techniques into one unified system or framework. Two specific approaches to integration involve the identification of common factors and the recognition of shared strategies, each of which we consider further here.

COMMON FACTORS

As Davis suggests in Chapter 13, a set of common factors lies at the base of couple therapy. These include common factors shared with individual therapy, such as the therapeutic alliance, the instillation of hope, and attending to feedback. Additionally, there is a second set of common factors unique to relational therapies that include maintaining a relational frame, an active therapy style, disrupting dysfunctional relationship patterns and supporting functional ones, and some effort to create a relational therapeutic alliance. Although not all models in this *Handbook* speak explicitly of common factors, most do attend to them. For example, it is rare to find a chapter that does not include a discussion of creating a therapeutic alliance and attending to its complexities.

SHARED STRATEGIES

Beyond common factors lies a wide array of strategies that either originated within one approach and migrated to other therapies or have emerged as important intervention pathways in different approaches (Lebow, 2014). For example, most approaches strive to promote some form of negotiation between partners, some form of mutual empathy and understanding, some engagement and focus on the strengths of the relationship, some affective reengagement of positive connection, some understanding of individual contributions to the conjoint problem, and some form of mindfulness or affect regulation to render conflict-based interactions more constructive. Frequently shared strategies include tracking patterns, listening, witnessing, psychoeducation promoting mentalizing, promoting softening, and building attachment. Notably, the naming of these shared strategies can often be a constraint in the recognition of shared ground. Terms such as "cognitive restructuring," "reframing," and "restorying" exemplify different jargon for similar interventions across approaches. Such jargon readily invites a Tower of Babel in which similarities across approaches are not recognized and small differences in methods are accentuated over common ground (Miller, Duncan, & Hubble, 1997). (Notable exceptions exist—for example, the use of the word "softening" in emotionally focused therapy has been enormously helpful in providing the perfect word for a broadly recognized intervention across diverse approaches.)

Arrangements

Given the many different approaches to couple therapy and the varying problems and purposes for which it is employed, the extent to which the pragmatics of when, with whom, and how often couple therapy is done is quite remarkable. Couple therapy today is primarily done conjointly, with a clear set of specified rules for any separate communication with individual partners. Sessions are most commonly conducted for 1 hour per week, and most methods include some carryover of the process (e.g., homework) between sessions. Couple therapy may continue for only a few sessions or last years, but most models envision a process lasting between 3 and 12 months. It is striking that even though there have been innumerable methods developed that are aimed to be conducted over either briefer or longer time frames, and with shorter or lengthier sessions, the standard remains mostly the standard. Whether this is driven by custom, by cost considerations such as insurance reimbursement, or by some shared notion that this is most effective remains an open question.

Couple Therapies Have Evolved from Their Origins

Couple therapy models emerged out of various theoretical traditions, each anchored in its own time of development. However, it is in the nature of psychotherapies that whereas theories and concepts often last over time, specific approaches do not. For example, in the first few versions of this *Handbook*, behavioral marital therapy was a distinct, singular approach. That original treatment has been largely supplanted by the considerably expanded cognitive-behavioral couple therapy (see Baucom, Epstein, Fischer, Kirby, & LaTaillade, Chapter 3) and integrative behavioral couple therapy (see Christensen, Dimidjian, Martell, & Doss, Chapter 4). Similarly, emotion-focused therapy has been succeeded by emotionally focused couple therapy (see Johnson, Wiebe,

& Allan, Chapter 6) and emotion-focused couple therapy (Goldman & Greenberg, 2015). In a like manner, early psychoanalytic therapies have been superseded by object relations couple therapy (see Siegel, Chapter 7) and mentalization-based couple therapy (see Bleiberg, Safier, & Fonagy, Chapter 8). And Bowen therapy and contextual therapy have been largely succeeded by a broader, more attachment-oriented version of intergenerational therapy (see Fishbane, Chapter 9). Other therapies often spoken of in early texts like this one, such as structural, experiential, and strategic couple therapy, have now declined as predominant models, although they still have a cadre of devoted followers, and their critical influence can be seen in various contemporary approaches (e.g., see Franklin, Zhang, Bolton, & Yates, Chapter 11, on solution-focused couple therapy). In tandem, the practice of some forms of couple therapy such as narrative therapy and emotionally focused therapy have vastly expanded and evolved (see Johnson et al., Chapter 6, and Freedman & Combs, Chapter 10). And newer forms of couple therapy have emerged, such as socioculturally attuned couple therapy (see Knudson-Martin & Kim, Chapter 12) and acceptance and commitment couple therapy (see Lawrence, Cohn, & Allen, Chapter 5), as well as numerous specific therapies targeting specific issues or populations.

A Central Role for Culture and Gender

Couple therapy began as "marital" therapy—that is, with a fixed set of ideas about who the couple comprised (a man and a woman), their legal status as a couple (married), and often with a stereotypical set of expectations having to do with roles and other aspects of the relationship. And from this perspective, marital therapy without much self-reflection often spoke primarily to the experience of White, middle- and upper-class Americans and Europeans.

Feminist, queer, and multicultural perspectives, as well as the dissemination of couple therapy around the world, have very much changed this perspective. Couple therapy is now a vehicle for helping with intimate relationships across gender, sexual preference, class and culture, and other facets of individual differences (see Knudson-Martin & Kim, Chapter 12). This has even affected the language for talking about couples. Consistent with the emerging consensus in the field, in instances where the text refers to a generic (gender nonspecific) singular subject, this book uses the pronoun "they" for that subject.

Understanding couples in the context of culture, gender, and sexual orientation has become an essential aspect of couple therapy. Furthermore, couple therapies are often most helpful when adapted to specific kinds of couples—for example, adaptations for lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples (see Coolhart, Chapter 23), stepfamily couples (see Papernow, Chapter 22), or Kelly and colleagues' (2019) description of the special considerations in therapy with Black American couples. These insights and practices do not require clinicians to relinquish their favored theoretical approach to couple therapy but do present crucial additional considerations in the context of working with couples in a sensitive and effective manner.

COMMON ELEMENTS OF COUPLE THERAPY

Assessment

In their chapter on couple assessment, Snyder and Balderrama-Durbin (see Chapter 2) argue that assessing multiple domains (e.g., emotions, cognitions, and behaviors) across multiple system levels (e.g., individual partners, their relationship, and broader family and cultural contexts) is essential for selecting, tailoring, and sequencing couple therapy interventions in a planful and effective manner. Although nearly all chapters in this *Handbook* address assessment issues, both theoretical models and specific applications of couple therapy vary in their advocacy of specific content or methods, their philosophical stance toward normative versus idiographic approaches, and their views on whether formal assessment necessarily precedes intervention or, instead, evolves organically throughout therapy. That said, the different chapters universally recognize the importance of attending to individual differences in conducting relevant interventions. Similarly, nearly all speak to the importance of monitoring both the process and progress of therapy in evaluating the impact of specific interventions and revising the clinical formulation (whether explicit or implicit) and plan of therapy accordingly.

Related to assessment is the specification of specific inclusionary or (more usually) exclusionary criteria for couple therapy. Most models of couple therapy advocate against conjoint interventions when one or both partners report moderate to severe partner aggression, suicidality, active alcohol or other substance abuse, continuing infidelity, or psychotic symptoms. This *Handbook* includes chapters describing specific couple-based treatments for some of these issues (e.g., Epstein, LaTaillade, & Werlinich, Chapter 17, for partner aggression; Gordon, Mitchell, Baucom, & Snyder, Chapter 18, for infidelity; or McCrady, Epstein, & Holzhauer, Chapter 25, for alcohol problems). Careful assessment facilitates informed decisions as to whether any of these or similar problems can be addressed within one of the theoretical models described in Part I of this *Handbook* or, instead, they require the more specialized intervention protocols presented in Part II on specific applications.

Myriad Strategies of Intervention and Techniques

Across the many chapters of this *Handbook*, one marvels at the richly distinct body of methods of intervention that have been developed. Clearly, some of the most creative and astute clinicians have developed this wonderful array of methods. The models described here bubble over with a potpourri of rich clinical illustrations interwoven throughout their exposition. Given this, couple therapists have available a panoply of active ingredients they can incorporate into treatment.

Notably, effective therapists often come up with very similar ways of working in couple therapy across whatever divides exist among theories. Clearly there also has been crosspollination, evidenced by the many cross-references in various chapters to other approaches in this *Handbook*. As already noted, language often continues to obscure similar constructs or techniques across approaches—with the same method (e.g., operations designed to heighten or diminish affect) being referenced by different names. That said, at times there are substantive and important differences in the nuances of methods (e.g., how directive to be in challenging a particular cognition, or how to label or incorporate historical influences) that should be considered when selecting and implementing various methods in a coherent manner.

The Systemic View: Sequences and Vulnerability Cycles

One important shared emphasis of almost all couple therapies lies in tracing the interpersonal sequences that unfold in the process of developing relational difficulties. This speaks to the influence of shared systemic understandings. Although certain processes may lie within individuals, the inevitable mutual influences between partners define the crucial understanding that is foundational to treating couples. It is in the nature of intimate relationships that the thoughts, feelings, and behaviors of partners inevitably affect one another and their relationship in an ongoing, recursive manner.

These cycles are named in a variety of ways across approaches, and what is seen as the specific internal component of greatest moment in these cycles varies from approach to approach. Thus, Breunlin, Russell, Chambers, and Solomon, in describing integrative systemic therapy in Chapter 14, refer to sequences. Fishbane, in the context of Chapter 9 about intergenerational therapy, speaks of the vulnerability cycle, whereas Johnson and colleagues refer in their discussion of emotionally focused therapy in Chapter 6 to mutual attachment injuries. Whatever the naming of the process, the core sequence being referenced here is a multilevel interpersonal process in distressed couples of turning away from one another or aggressively toward each other as opposed to compassionate engagement. The models in this *Handbook* articulate how these processes, like rust corroding the foundation of bridges, can erode the positive connection between partners. The chapters in the first section of this *Handbook* describe how couples can develop and maintain a vital loving connection and the processes by which such connections diminish, whereas the chapters about specific problems and issues (e.g., Monson & Fredman, Chapter 24, on posttraumatic stress disorder [PTSD], or Hall & Watter, Chapter 19, on sexuality) emphasize how those issues come to be interwoven in the broader fabric of individual and relational functioning.

Whom to Include in the Couple Therapy

As noted earlier, contemporary approaches almost universally operationalize couple therapy as uniquely involving conjoint sessions with the two relationship partners. That said, there are exceptions. For example, some theoretical models and specific applications advocate for inclusion of individual interviews during the initial assessment. Some suggest infusing individual sessions during the couple therapy as a means for disrupting unremitting, escalating negative exchanges until better self-regulation can be achieved with the individual partners and then incorporated into resumed conjoint sessions. Some models have more flexible boundaries about whom to include, based on partners' own conceptualization of significant participants in their relationship (see, e.g., discussions of direct and indirect client systems in integrative systemic therapy by Breunlin et al. in Chapter 14, or incorporation of adult children by Knight in therapy with older adult couples in Chapter 20).

Pragmatic Focus on Relationship Satisfaction

Another clear point of overlap lies in a dual focus on reducing couple distress and promoting relationship satisfaction. Almost all couple therapies emphasize specific interventions targeting these two, complementary outcomes. That said, models vary in their relative emphasis on one versus the other. By definition, couple-based applications for specific relationship issues (e.g., partner aggression or infidelity) or individual problems (e.g., depression or anxiety disorders, alcohol problems, acute medical issues) target reduction in these difficulties, with improvement in relationship satisfaction often being viewed as one of the mediating pathways. Historically, many couple therapies have focused more on reducing conflict than on promoting intimacy—although, more recently, such positive aspects of relationships as increasing emotional connection and shared meaning have moved into greater focus. Theories of couple functioning and related models of intervention play a pivotal role through their differential emphasis on specific aspects of relationships such as attachment, mentalization, mutual acceptance, problem solving and communication, narratives, or gender or cultural consciousness.

Two activities closely related to couple therapy bear noting when considering the goal of relationship satisfaction. The first involves various programs aimed at *prevention* rather than *treatment* of couple distress. Relationship education and distress prevention have a long history (indeed, the origins of marriage counseling in the 1930s can be traced to this focus), and federal funding initiatives in the 21st century have tended to prioritize prevention over remediation, with a strong focus on diverse higher-risk populations (see the discussion of relationship enhancement and distress prevention programs by Carlson, Rhoades, Johnson, Stanley, & Markman, in Chapter 29). The second activity involves couples in which one or both partners have decided (explicitly or implicitly) to end their relationship. There, as discussed by Lebow in Chapter 21, the goals target reaching an explicit decision and helping partners to end their relationship (if that is the choice of one partner or the other) in a manner that minimizes further harmful impact and facilitates subsequent individual well-being for the adult partners and any offspring.

The Role of the Therapist

The role of the couple therapist represents an aspect of therapy about which there is more debate. Certainly, all acknowledge the therapist as a vital part of a system with the couple, and all accentuate the importance of alliance and collaboration. That said, the various models differ in how they regard the therapist's position in relation to both partners and the roles they ideally fulfill. Some approaches, such as cognitive-behavioral couple therapy, emotionally focused couple therapy, Gottman method therapy, and integrative behavioral couple therapy look to therapists to be highly directive. From these approaches, the therapist functions largely as a dispenser of information and catalyst for developing better ways of connecting and managing differences. By comparison, in other approaches such as narrative couple therapy and object relations couple therapy, therapists are envisioned as much less directive. From these perspectives, the therapist comments and joins rather than directs; in the narrative approach, therapists even defer to the partners' unique expertise about their own relationship. The directiveness of a cognitive-behavioral couple therapist would likely make a poststructural narrative therapist uncomfortable, and the lack of certainty in the poststructural position would do the same for more directive therapists. Notably, across the couple therapies described in this *Handbook*, self-disclosure seems rarely mentioned. Of course, many therapists do self-disclose (e.g., in describing their personal experiences in relationships from an educational or empathic perspective), but such patterns do not seem to be associated with a specific theoretical orientation or tend to be highlighted in presentations of the key aspects of practice.

Ethical Considerations

Couple therapists across orientations recognize a shared set of ethical considerations. Although couple therapies may disagree about what is the optimal ethical decision in a specific circumstance (e.g., whether to hold small secrets), there is almost total agreement on where the ethical issues lie and how to think about those issues. Thus, Margolin, Gordis, and Rasmussen's discussion about ethics in couple therapy in Chapter 31 speaks to almost all couple therapies regardless of the specific application or underlying theoretical model. Couple therapists struggle with the same complex set of dilemmas and questions, and most often come up with similar answers about issues such as confidentiality about private communication with one partner during couple therapy; about identifying who the client is in therapy, and how to respond to one partner's desire to leave the relationship; or about how to deal with the risk of intimate partner violence. Sometimes, there are differences about what is to be done in a specific circumstance, but across chapters in this *Handbook*, it is rare for an idea about these issues to be presented without recognizing that others may hold different positions and an awareness of the complexities involved in holding particular positions.

Relation to Individual and Family Therapy

Even as couple therapy has differentiated itself from individual and family therapy, it also has found a place for these modalities. Most of the methods in this *Handbook* coexist and often actively look to be enhanced through collateral work with an individual partner. Although in some models that work may be done within the couple format, many of the chapters suggest a complementary role for concurrent individual therapy with a different therapist.

Ironically, given its systemic roots, concurrent family therapy is less frequently spoken of in this *Handbook* than is individual therapy. Family systems considerations emerge more prominently in special circumstances—for example, when working with couples in which one partner leans toward ending the relationship while the other wants to continue with it before making a decision to enter couple therapy, where the impact on children typically arises as an important factor (Doherty & Harris, 2017). Similarly, Wymbs, Wymbs, and Canu speak in Chapter 27 to the role of working with couples as part of a multiformat approach with families of youth with ADHD or disruptive behavior disorders, and Ruddy and McDaniel (Chapter 28) describe how therapy with couples with medical issues is integrated with medical family therapy. More broadly, Fishbane (see Chapter 9) and Breunlin and colleagues (see Chapter 14) show how intergenerational work with couples may readily segue to sessions with families of origin.

Stages of Couple Therapy

Although there are exceptions, most couple therapies envision beginning therapy with a stage of assessment and building of the therapeutic alliance, followed by a stage of promoting change (e.g., reducing couple distress and fostering positive connection), then a concluding stage of termination and maintenance of gains. In the initial stage, many approaches include an explicit sharing or co-creation of the clinical formulation and tentative treatment plan, reflecting emerging emphases in the field on collaboration and transparency in all phases of the couple therapy.

FACETS OF DIFFERENCES ACROSS APPROACHES

Despite the underlying pragmatism and integration evident in many contemporary couple therapies, theories do matter. In his seminal 1978 analysis, Alan Gurman spelled out the essential tenets of what then were the major schools of couple therapy: behavioral, psychoanalytic, and systemic approaches. In this classic deconstruction of couple therapies, Gurman differentiated couple therapies along four dimensions: (1) the role of the past and of the unconscious, (2) the nature and meaning of presenting problems and the role of assessment, (3) the relative importance of mediating versus ultimate treatment goals, and (4) the nature of the therapist's roles and functions. Fraenkel (2009), following a similar analysis, highlighted that approaches differ in (1) time frame (present, past, or future), (2) change entry point (thoughts, emotion, or behavior), and (3) degree of directiveness. It is striking (although perhaps not surprising) that now, decades later, these key facets of differences still apply today.

Earlier in this chapter, we noted multiple sources of commonality across couple therapies—including shared systemic understandings, integration of specific techniques across approaches (even if reconceptualized within an alternative theoretical framework), the broadening of therapeutic focus (i.e., the near-universal consideration of thoughts, feelings, and behaviors), and common arrangements (e.g., the emphasis on conjoint sessions). That said, while sharing considerable foundational elements, couple therapies in the 21st century can be differentiated along multiple dimensions—including (but extending beyond) those cited in previous analyses—both in terms of unique components as well as their relative emphasis on various shared components.

Authors contributing to this *Handbook* were encouraged to address a prescribed set of both theoretical and pragmatic considerations essential to their approach (whether a specific model of couple therapy or application to a specific issue or population). This shared structural organization across chapters facilitates readers' comparisons of the couple therapies described herein across specific facets that illuminate their distinct features. Below, we summarize some of the most important, differentiating facets of various couple therapies.

The Defining Elements of a Successful Relationship

What are the most essential features that define a successful couple relationship? What are the typical individual elements, relationship patterns, or broader systemic characteristics that differentiate healthy or well-functioning couples from those challenged by distress or dysfunction? Relatedly, what implicit or explicit theory of love and connection underlies a particular therapeutic model? For some, the answer lies in growing the couple friendship; for others, in attachment; for still others, in how partners think and feel about their relationship; for some, the broader historical or cultural context; for others, sexuality; and, for still others, deep intrapsychic needs and capacities to connect. Although it is now typical for various models to speak to multiple levels of experience, the therapeutic approaches in this *Handbook* tend to emphasize one predominant lens in their theory of love, connection, and health.

Specific Arrangements

Couple therapy, both in its theoretical iterations and its applications to specific issues or populations, overwhelmingly emphasizes meeting with both partners conjointly. However, exceptions exist across approaches—whether in conducting the initial assessment; incorporating individual sessions to promote better emotion regulation enabling conjoint sessions to be more constructive; or pursuing individual partner issues separately when couple dynamics don't yet permit exploration of those issues in conjoint sessions but referral of the partner to concurrent individual therapy doesn't appear warranted. Specific policies for handling confidential communication in such individual meetings may also vary across approaches.

Couple therapies also vary in the extent to which other exceptions to conjoint sessions involving the two partners may be accepted or even encouraged. For example, earlier in this chapter we noted discussions of direct and indirect client systems in integrative systemic therapy (see Breunlin et al., Chapter 14) or sessions including adult children in therapy with older adult couples (see Knight, Chapter 20). In her discussion of stepfamily couples, Papernow (Chapter 22) notes that ex-spouses are a permanent part of the family; hence, couple therapists may need to incorporate time-limited intervention with ex-spouses to promote more collaborative co-parenting across households. Coolhart (Chapter 23) notes that in some polyamorous relationships there is no hierarchy, and all relationships are treated as equally important; within that context, discussions of interpartner conflict, attachment, security, jealousy, or relationship roles and boundaries could easily require reconfiguration of couple therapy from a dyadic to a broader multipartner context.

Separate from issues of "whom to include" are the setting for the couple work. At the pragmatic level, where to conduct the therapy may be influenced by medical issues, mobility, systemic constraints (e.g., access to child care or transportation), and a host of related concerns noted across chapters in this *Handbook*. Telehealth may reduce but not eliminate those constraints (i.e., depending on access to, and proficiency with, relevant technology). At a broader conceptual level, approaches to couple therapy vary in how much they consider the couple "work" to extend outside of sessions to between-session (e.g., at-home) prescribed exercises or enactments and the use of such materials as worksheets or ancillary texts.

The Role of Assessment and Case Formulation

How do the different couple therapies view the role of assessment and case formulation? Whether implicitly or explicitly, all therapists need to attend to the unique characteristics of individual partners, their relationship, and their broader socioecological context. However, some approaches advocate meticulous assessment and the generation of an explicit case formulation and treatment plan, whereas others do not. Some approaches such as narrative therapy explicitly eschew assessment. And among those approaches that specifically incorporate issues of assessment, there may be a formal stage of assessment (e.g., a four-session protocol combining individual and conjoint meetings) or not; similarly, the various approaches or specific applications may prescribe standardized questionnaires or a set of observational tasks, or not.

Roles of the Therapist

Influences on the Therapeutic Process

Although the various approaches to couple therapy universally recognize the importance of the therapeutic alliance as a common factor (see Davis, Chapter 13), they differ considerably in how they envision the therapist influencing (and being influenced by) the therapeutic process. Some (e.g., the more traditional behavioral approaches) envision the therapist as an expert in relationships, dispensing wisdom and correcting dysfunctional patterns. Others (e.g., poststructural approaches) emphasize the therapist's and couple's collaborative coconstruction of the treatment goals and strategies, during which the therapist participates as a "fellow traveler" who facilitates the partners' realization of their own unique goals and pathways toward attaining these. Most approaches locate themselves somewhere midway along the continuum between expert guide and fellow sojourner.

Attention to Self of the Therapist

Couple therapies also vary in how much they attend to "self of the therapist" as an integral component of the therapy process. From this perspective, therapists need to pursue mindfulness of their own thoughts and emotions, memories, values, and implicit assumptions or biases in order to draw on both their past and present experiences in relating and intervening with couples (Aponte & Kissil, 2016). Some models emphasize such self-awareness as an essential core component of effective therapy—for example, socioculturally attuned couple therapy (see Knudson-Martin & Kim, Chapter 12), object relations couple therapy (see Siegel, Chapter 7), therapy with queer couples (see Coolhart, Chapter 23), and even therapy with older adult couples (see Knight, Chapter 20) given younger therapists' often erroneous (and potentially harmful) notions of such issues as sexuality or disability in this population.

Notably, approaches that once highly emphasized self of the therapist and therapist self-disclosure (e.g., Whitaker's symbolic–experiential therapy; Whitaker, 1958; Whitaker & Keith, 1981) now play a less prominent role in couple therapy. It is also notable that whereas many early models explicitly called on therapists in training to participate themselves in couple therapy, no chapters in this edition of the *Handbook* do so.

Some approaches encourage therapist self-disclosure, whereas many others do not. Most models leave open the possibility without being explicit about guidelines for self-disclosure. Yet transcending these differences, most approaches encourage therapists to recognize and draw on their own subjective experiences during the therapy process (e.g., feelings of empathy, irritation, or boredom) as important information regarding the content and process of interactions with the couple or between partners themselves.

Levels and Focus of Interventions

By definition, couple therapies focus on the couple dyad and, for the most part, on the aggregate subjective balance of couple distress versus well-being. However, within that general framework, approaches vary a lot in their consideration of multiple system levels including individual partner characteristics, aspects of the extended family, and the broader socioecological context. Approaches also vary in their relative emphasis on emotions, cognitions, and behaviors—and the explanatory or conceptual lenses through which each of these is understood.

Levels of Intervention

Contemporary approaches to couple therapy all share a systemic perspective, but for some it is far more central than for others with different emphases. For example, in object relations therapy (see Siegel, Chapter 7) and intergenerational approaches to couple therapy (see Fishbane, Chapter 9), the enduring and predisposing vulnerabilities of the individual partners, rooted in their respective family and prior relationship histories, constitute the foundational substrate from which interactive vulnerabilities, self- and partner perceptions, and exaggerated response dispositions evolve. By contrast, other therapies focus on broader contextual factors as contributing or perpetuating influences on couple distress or dysfunction. From this perspective, influences such as systemic poverty, racism, or heterosexist and cisgender bias not only moderate the development or treatment of couple distress but they also directly contribute to it (Hardy & Bobes, 2017) and, hence, become a central focus of treatment (see, e.g., Knudson-Martin & Kim, Chapter 12, on socioculturally attuned therapy and Coolhart, Chapter 23, on therapy with queer couples).

Moreover, the various approaches may target individual problems, relational problems, broader systemic influences, or any combination of these—either in their underlying theoretical formulation or in their specific application (as in the application of cognitive-behavioral couple therapy to individual disorders).

Focus of Intervention

Similarly, contemporary couple therapies vary in their relative focus on specific content, regardless of the system level of intervention. Most all recognize the interactions among thoughts, feelings, and behaviors, but their emphases on one or another of these domains differ considerably. Even the labeling of the approaches reflects these differences—for example, cognitive-behavioral versus emotionally focused couple therapy. Furthermore, there is argument even across approaches that target multiple dimensions of experience about the optimal sequence for addressing these. For example, some suggest behavior should be addressed first (e.g., integrative systemic therapy), whereas others initially emphasize processes such as attachment (e.g., as in emotionally focused couple therapy) or acceptance (e.g., as in integrative behavioral or acceptance and commitment therapy for couples). Moreover, partners may be encouraged to attend primarily to the subjective experiences of each other (e.g., to promote empathic awareness and joining) or, instead, to pursue mindfulness of their own thoughts and feelings as these influence relational exchanges (e.g., as in acceptance and commitment couple therapy).

Also influencing the content of interventions are approaches' differential attention to levels of awareness related to subjective thoughts and feelings. For example, partners' expectations of themselves and each other may reside well within conscious awareness, may lie outside immediate awareness but prove accessible with modest guidance from a cognitive framework, or may rely on techniques more typical of various psychodynamic approaches for uncovering latent internal processes and explicating their influence in the current relationship. Sager's (1976) work on "hidden forces" in couple relationships, and the impact of these forces on both implicit and explicit contracts (and their degrees of congruence or discordance), offered an influential explication of levels of consciousness as related to different approaches to intervention.

The various approaches to couple therapy also differ in their relative emphases on overt change (e.g., cognitive-behavioral and solution-focused couple therapy) versus acceptance (e.g., integrative behavioral couple therapy). Notably, even among those therapies that emphasize acceptance, approaches vary in how they conceptualize and promote this outcome. For example, in integrative behavioral couple therapy, acceptance is pursued through specific interventions promoting empathic joining (emotional change) and unified detachment (cognitive change) as an alternative (or precursor) to interventions targeting behavioral change (see Christensen et al., Chapter 4). In acceptance and commitment therapy, partners are encouraged to experience uncomfortable internal experiences and to tolerate their presence rather than trying to control them, so that they can allocate their time, energy, and attention in more fulfilling ways (see Lawrence et al., Chapter 5). In the various psychodynamic and multigenerational approaches, partners' acceptance evolves from changes in understandings of their own and each other's developmental histories and associated vulnerabilities—that is, through partners' more compassionate interpretations or meanings (and hence, related feelings) connected to specific behaviors or interaction sequences.

Presumed Mechanisms of Change

Closely related to levels and focus of interventions are the various approaches' underlying theoretical tenets regarding mechanisms of change. Separate from their shared emphasis on the therapeutic alliance, most approaches first prioritize attending to disabling individual or relationship crises. Beyond such shared initial "stabilization" interventions, however, the various approaches' theoretical precepts guide the selection, sequencing, and even pacing of specific interventions. Some models, for example, prioritize behavior change (or problem solutions) as the mediating pathway for promoting partners' positive thoughts and feelings for one another. Others prioritize interventions aimed at altering partners' thoughts toward one another—including the interpretations or meaning they give to relational events (whether explicit or implicit) as the mediating pathway for reducing negative affect derived from subjective meaning and, by reducing subjective negativity, thereby fostering more positive exchanges. And still other approaches prioritize interventions aimed at promoting emotional connection (e.g., via vulnerable emotion expression and empathic responding) or acceptance (e.g., tolerance of inevitable differences). From any of the pluralistic or integrative approaches, the therapist could select specific interventions from across theoretical models, based on their presumed mechanism of change and in congruence with the case formulation.

The Temporal Framework of Interventions

How important is the exploration of partners' individual and shared histories? Some approaches, such as intergenerational ones (see Fishbane, Chapter 9), are fully anchored in the past and may begin with genograms as both an assessment and intervention method. Others, such as solution-focused therapy (see Franklin, Zhang, Bolton, & Yates, Chapter 11), are almost exclusively present focused. Most contemporary couple therapies incorporate attention to both distal (historical) and more proximal (recent or current) influences, although often to different degrees or in different sequences. (For example, in Snyder's [1999] pluralistic approach, developmental influences are pursued only after more structural or cognitive-behavioral interventions fail to achieve desired outcomes.) Moreover, in various integrative approaches or specific theoretical models incorporating particular techniques from alternative approaches, the labeling of techniques or their interpretation through a particular theoretical lens may obscure similarities in their application (e.g., identifying projective identifications in object relations therapy, attachment injuries in emotionally focused therapy, or acquired perceptual and behavioral response dispositions in cognitive-behavioral couple therapy).

Manualized versus Improvisational Approaches

Contemporary couple therapies vary in their level of structure—ranging from those that are more improvisational (even naming improvisation as a core aspect of the therapy; see Fraenkel, Chapter 15, on the therapeutic palette integrative approach), to those that are more prescriptive regarding the sequence and general content of interventions (e.g., couple therapy for partner aggression or infidelity). Some approaches (e.g., Gottman method therapy and Papernow's therapy for stepfamily couples) propose specific goals of intervention and methods of accomplishing those goals, although the sequence and number of sessions devoted to each goal may be tailored to aspects of the individual partners and their relationship. Applications of couple therapy to individual problems such as PTSD or alcohol abuse, similar to their cognitive-behavioral counterparts in individual therapy, tend to be more highly structured or manualized—often with a specific sequence and prescribed "curriculum" detailing specific sessions.

Intermediate versus Ultimate Goals and Decisions about Termination

Couple therapy can be open ended or time limited. Solution-focused couple therapy likely anchors this continuum by its explicit focus on brief interventions targeting circumscribed problems. Other couple therapies of all varieties may segue into an ongoing activity over many years, potentially reflecting a transition from initial interventions promoting specific relationship skills to a subsequent emphasis on partners' individual growth within a conjoint framework. Most contemporary couple therapies terminate after sufficient progress toward initial goals has been achieved, with the modal duration of treatment somewhere between 3 and 12 months. Longer durations may be anticipated, regardless of approach, with couples for whom individual, relational, or broader systemic dysfunctions are more severe, more complex or pervasive across multiple domains, or more entrenched across time.

Gurman's (1978) distinction between mediating and ultimate treatment goals also provides a useful heuristic for viewing shorter- versus longer-term approaches. For example, when situational stressors compromise partners' functioning and couple well-being, initial goals may involve resolving those stressors to achieve a direct (and potentially sufficient) effect on reducing couple distress. However, if in the course of that work the therapist determined that traumatic individual developmental experiences mediated the impact of current stressors on individual and relational functioning, then stress reduction might shift to being an intermediate goal and the "ultimate" goal might be reconceptualized as emotional or cognitive reprocessing of traumatic experiences to reduce or resolve their contribution to recurrent patterns of vulnerability or exaggerated reactivity. In the final analysis, the formulation of treatment goals and related decisions about termination inevitably reflect an evolving interaction between the therapeutic approach and couples' own values, aspirations, and resources.

EMERGING ELEMENTS

Examination of chapters in this *Handbook* also reveals an exciting array of emerging elements in contemporary couple therapies.

Technology

The COVID-19 pandemic potentiated a trend already developing in couple therapy toward telehealth and using electronic media as extensions of therapy. Much of couple therapy delivered during the pandemic shifted to videoconferencing. Therapists needed to augment and adapt their methods to a context during which face-to-face meetings were not possible. Fairly quickly, several useful sets of guidelines for relational teletherapy were offered (Burgoyne & Cohn, 2020; Hardy, Maier, & Gregson, 2021; Hertlein, Drude, Hilty, & Maheu, 2021). Couple therapists discovered that virtual therapy works (De Boer et al., 2021) and, in many situations, works equally well as in-person sessions (e.g., when partners are geographically separated by work, deployment, or other factors). Furthermore, videoconferencing solves one of the major constraints of couple therapy that historically had caused so many who could benefit from couple therapy not to seek it—namely, individual control over the time and place of meeting. For many persons, meeting virtually from their homes or from work is easier, and therapists can often be more flexible with scheduling of sessions in this format. It can be relatively easy to assemble a couple in virtual space, and often much harder to do so in person. Numerous chapters in this edition of the *Handbook*, for the first time, refer to these now ubiquitous methods of videoconferencing. The new chapter on telehealth and digital couple interventions (see Doss, Knopp, Wrape, & Morland, Chapter 30) explicitly focuses on the increasingly central role that technology will likely play in couple therapy in the future.

Beyond using videoconferencing services for couple therapy, there is considerable growing excitement about the application of Web-based resources as adjuncts to treatment (see Doss et al., Chapter 30) or in relationship education (see Carlson et al., Chapter 29). Models on the technological cutting edge such as Gottman method therapy (see Gottman & Gottman, Chapter 16) now regularly augment couple therapy with online psychoeducational materials, reminders to engage in prescribed behaviors, and even physiological measures of partners' autonomic arousal.

Specific Treatments for Specific Problems and Populations

Couple therapy has traditionally been mostly envisioned as a process aimed at improving relationship satisfaction or, at least, as deciphering the viability of committed relationships. However, over the last 20 years, couple therapies have been developed and widely disseminated focusing on problems traditionally viewed as residing within individuals. Thus, the section in this *Handbook* on couple-based interventions for individual problems advances considerably with each edition. Baucom, Belus, Adelman, Fischer, and Paprocki (2014) provide a useful distinction between partner-assisted and disorder-focused interventions targeted at individual problems. In partner-assisted interventions, the partner is enlisted to help in the process of reinforcing and supporting the active treatment of the individual problem. In contrast, in disorder-specific treatment, the treatment itself is couple therapy tailored to the particular kinds of couple dynamics likely to occur in the context of the partner's individual problem.

Today, in response to the dominance of cognitive-behavioral therapies for the treatment of individual disorders, couple treatments of individual problems are also mostly cognitive-behavioral in their approach. However, other models, such as emotionally focused couple therapy and mentalization-based therapy, have begun to speak to such uses of couple therapy across several specific disorders (see Johnson et al., Chapter 6, and Bleiberg et al., Chapter 8), and one could anticipate that such applications of other theoretical models of couple therapy to treat individual emotional or physical health problems will continue to proliferate.

Couples often present for therapy to receive assistance with issues around parenting of their children or adolescents. In their discussion of couple therapy with parents of youth with ADHD or disruptive behavior disorders, Wymbs and colleagues (see Chapter 27) emphasize that traditional behavioral training programs, while promoting positivity in parent–child interactions, give only limited attention to the relationship between parents. Many family therapy models for parents and adolescents with various disorders (e.g., conduct disorder or substance misuse) also underattend to the couple relationship itself and its recursive influences upon and from the adolescent's behaviors. As Wymbs and colleagues note, it is virtually inevitable that parents will experience occasions of disagreement or other challenges when rearing children together. Couple challenges associated with children's behaviors become more frequent, severe, and difficult to resolve when offspring have their own individual problems—whether these take the form of internalizing, externalizing, or neurodevelopmental disorders. Expositions of couple therapy with parents of youth with emotional or behavioral disorders have been notably absent, and the chapter by Wymbs and colleagues offers a much-needed general framework for tailoring interventions to couples struggling with these common concerns.

Reaching Out to a Wider Range of Couples

As culture and gender have become more central considerations in couple therapy, approaches explicitly addressing issues of diversity have also emerged and gained broader traction. Exemplars in this *Handbook* include the discussions of therapy with queer couples (see Coolhart, Chapter 23) and interventions involving sexuality (see Hall & Watter, Chapter 19), both of which reflect important advances in the ways of thinking about and working with couples. Similar explicit attention to diverse couples is found in Papernow's discussion of therapy with stepfamily couples (see Chapter 22) and Knudson-Martin and Kim's exposition of socioculturally attuned therapy (see Chapter 12), as well as therapy targeting couples from specific ethnic groups (Boyd-Franklin, Kelly, Durham, & Gurman, 2008; Chambers, 2019; Falicov, 2014; Kelly, Jérémie-Brink, Chambers, & Smith-Bynum, 2020).

Old formulations of relationships or guidelines for therapy are now viewed through new lenses. The expansion in the breadth of couples embraced by the field of couple therapy and explicitly featured in this *Handbook* has been enormous since its first edition nearly 40 years ago. For example, in this sixth edition, nearly all theoretical approaches to couple therapy explicitly address issues of applicability to LGBTQ couples. Furthermore, this broadening of the vision of who is involved in couple therapy has unearthed culture-bound assumptions and led to adaptations and advances in the core models of couple therapy in both their development and delivery.

The Interface with Relationship Education

Relationship education has a long and distinguished history, as it developed in parallel with couple therapy (see Carlson et al., Chapter 29). Relationship education and enrichment programs of late have become ubiquitous. This has promoted lively conversations about which couples (or individual partners) are most appropriate for which activity, about the fuzzy boundaries between education and treatment, and how to manage or optimize the interface between them. Whereas at one time it was clear that couple therapy was targeted to distressed couples and relationship education aimed at preparation and enrichment of better functioning relationships, this boundary has become much more fluid (Bradford, Hawkins, & Acker, 2015). Furthermore, several models of couple therapy included in this *Handbook* (e.g., see Christensen et al., Chapter 4, on integrative behavioral couple therapy and Johnson et al., Chapter 6, on emotionally focused couple therapy) describe adaptations of those models intended for either in-person, videoconference, or self-directed online psychoeducational relationship education programs.

The Growing Emphasis on Acceptance

Acceptance has moved into a much more prominent place in several methods of couple therapy, including integrative behavioral couple therapy, Gottman method therapy, acceptance and commitment couple therapy, and mentalization-based couple therapy. At one time, change was the focus of every couple therapy; now, many seek primarily to promote mutual acceptance, while also facilitating a framework for change. Still, there is the complexity of recognizing the boundary between promoting acceptance and dealing with avoidance or codependency in the wake of major difficulties.

Collaborative Therapists

There also was a time when couple therapy was largely a didactic set of processes in which the therapist as expert taught partners about how to be in a couple. Although this remains a thread in the work of several approaches such as cognitive-behavioral couple therapy and Gottman method therapy, or in the applications of couple therapy to specific relational issues or individual problems, overall, the field has moved from implicit views of a somewhat hierarchical therapist–couple relationship toward a much more collaborative stance. A collaborative stance goes well beyond elements of promoting a therapeutic alliance initially identified in client-centered individual therapy (i.e., genuineness, warmth, and noncontingent positive regard). Rather, collaboration extends to co-constructing therapeutic goals that incorporate partners' own views of individual and relationship health, their values rooted in their unique developmental histories and broader cultural contexts, and their own priorities regarding the balancing of individual with relationship interests in determining how to select and sequence treatment objectives and methods. Couple therapy models such as solution-focused, narrative, and the therapeutic palette exemplify an explicit stance that views partners as the best experts in their own couple processes.

Addressing Sexuality

Sexuality is clearly a central aspect of relational life, both in itself and in its association to attachment. Hence, it is somewhat bewildering why, in most models of couple therapy, it is so tangentially addressed. Notably, this core component of relationships is principally addressed in this book in the chapters on sexuality (see Hall & Watter, Chapter 19), LGBTQ couples (see Coolhart, Chapter 23), and older adults (see Knight, Chapter 20). These chapters highlight essential evolutions in the consideration of sexuality when working with couples. First, couple therapists need to challenge their own implicit attitudes or assumptions and expand their knowledge base and skill sets when addressing sexuality in working with sexual and gender minority couples. Similarly, therapists need to become familiar with and comfortable in discussing aspects of sexuality that may vary in specific populations—such as older adults or couples confronting specific medical problems (see Ruddy & McDaniel, Chapter 28). Finally, as Hall and Watter highlight in Chapter 19, couple therapy around issues of sexuality has evolved beyond addressing specific sexual dysfunctions and, instead, now embraces broader goals of promoting greater sexual awareness, improving sexual responsiveness, and enhancing sexual intimacy and enjoyment that might benefit any couple.

Attending to the Life Cycle

Both the challenges and benefits of being a couple vary across the life cycle. Most models of couple therapy have implicitly centered on midlife couples, and the specific issues and intervention strategies they emphasize do not always generalize either to younger couples early in their individual and relational development, or to older couples for whom individual and relational challenges and resources often change. The good news here is that many models have now evolved to incorporate couple development over time as a part of their vision. Beyond this, there is an emerging increased focus on specific stages of development and the typical issues in couples related to those life stages. For example, in Chapter 20, Knight speaks to special issues in older couples, while Papernow speaks in Chapter 22 to the unique issues and challenges that confront stepfamily couples. Other chapters highlight the complexities for young couples in emerging adulthood, particularly around decisions to formalize a committed relationship or transition to parenthood; moreover, specific couple interventions have been developed for working with this population (see, e.g., Gottman, Gottman, & Shapiro, 2010). From a broader perspective, the question of how to keep relationships vital and connected over a lifetime underlies the presentations in nearly every chapter.

Divorce

Whither divorce in couple therapy? Long regarded as a disastrous negative outcome, divorce is now reenvisioned as a potential positive pathway for couples, yet one fraught with challenges. New versions of intervention have recently been developed to help couples who face the possibility of divorce. For example, Doherty and Harris (2017) offer discernment counseling targeted to those not yet ready for couple therapy who are ambivalent or have mixed agendas about whether they want to divorce, to help the partners decide on whether working on their relationship further in couple therapy is indicated. How to work with those considering divorce, with the therapist finding a balanced position toward couples remaining together or parting, has become an essential aspect of couple therapy. So has helping those who decide to divorce to pursue the best outcomes for themselves and for the children who may be impacted (see Lebow, Chapter 21). Couples often envision couple therapy ending at the decision to divorce, but “divorce therapy” is paradoxically an essential part of the repertoire of the skilled couple therapist.

ADDITIONAL CHALLENGES

Contemporary couple therapies face numerous challenges—some enduring since the inception of the field (e.g., attention to individual differences and issues of diversity; balancing interventions to address intrapersonal, dyadic, and broader systemic sources of distress)—and others more recent (e.g., integrating technology; securing recognition across private and public health care systems). Some challenges are either explicit or implicit in earlier parts of this chapter (e.g., decisions regarding whom to include in the couple therapy; the balancing of acceptance vs. change; or specific ethical dilemmas). Beyond these, two additional challenges warrant consideration.

Maintenance of Gains

One crucial challenge for couple therapy is maintenance of therapeutic gains. Research has shown couple therapy to be highly effective in improving relationship satisfaction in most couples in the short term (Bradbury & Bodenmann, 2020; Roddy et al., 2020) but vulnerable to problems returning over the long term (that is, at 2 years or longer after termination). From the few controlled clinical trials of couple therapy and one uncontrolled evaluation examining couple outcomes 4–5 years posttreatment, nearly all show deterioration or divorce occurring for roughly 35–50% of couples (Snyder & Balderrama-Durbin, 2020). Exceptions to this general finding such as Snyder, Wills, and Grady-Fletcher's (1991) controlled trial of insight-oriented therapy, yielding a deterioration/divorce rate of 20% at 4 years posttreatment, have not been replicated.

Moreover, couple relationships evolve and different stages of the life cycle beget different problems. Thus, it would not be unexpected for a couple who has worked through problems at one stage of life to have prior problems return or different ones develop as time passes, events occur, and new circumstances arise. For this reason, most contemporary couple therapies include some specific interventions prior to termination aimed at dealing with issues that may arise in the future. However, despite their obvious intuitive appeal, the efficacy of those interventions in forestalling or reducing future deterioration or divorce remains unknown.

Client Values

Couples exist within a broader socioecological as well as historical context. So, too, do the various models of couple therapy intended to treat couple distress and promote individual and relationship well-being. That said, the contexts in which various couple-based interventions were developed, and in which couple therapists are trained, may not mirror the diverse and emerging contexts shaping the set of values that each partner brings to therapy. How can couple therapists conduct effective therapy in a world in which values differ so mightily within and across couples? Couple therapy and, more importantly, couple therapists, must remain aware, flexible, and responsive in a world in which both conceptual models and related interventions are applied across diverse populations and cultures with dramatically differing core beliefs and customs.

CONCLUDING COMMENTS

This is an exciting time in the history of couple therapy. Both collectively and individually, the chapters in this *Handbook* present the best of contemporary couple-based interventions. Each offers an integration of evidence-informed principles with clinical wisdom in the best of the scientist-practitioner tradition. With a strong foundation in relational science and evidence for their efficacy, these approaches are mature in their development. This *Handbook* highlights the diversity of not only our most prominent approaches but also an emerging and shared understanding of couples and couple-based interventions.

Similar to the challenges of choosing among various dishes at the most elegant buffet, readers may feel challenged to consume and digest all that the various chapters have to offer. We encourage you to take your time, savor the unique flavors, and return frequently to discover subtle nuances and pleasures not initially recognized. Embrace both the familiar and the new—allowing your own therapeutic *palate* (as well as *palette*) to develop and mature with time and experience.

REFERENCES

Aponte, H. J., & Kissil, K. (2016). *The Person of the Therapist Training Model: Mastering the use of self.* New York: Routledge/Taylor & Francis Group.

Baucom, D. H., Belus, J. M., Adelman, C. B., Fischer, M. S., & Paprocki, C. (2014). Couple-based interventions for psychopathology: A renewed direction for the field. *Family Process, 53,* 445–461.

Baucom, D. H., Hahlweg, K., & Kuschel, A. (2003). Are waiting-list control groups needed in future marital therapy outcome research? *Behavior Therapy, 34,* 179–188.

Bernet, W., Wamboldt, M. Z., & Narrow, W. E. (2016). Child affected by parental relationship distress. *Journal of the American Academy of Child and Adolescent Psychiatry, 55,* 571–579.

Boyd-Franklin, N., Kelly, S., Durham, J., & Gurman, A. S. (2008). African American couples in therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 681–697). New York: Guilford Press.

Bradbury, T. N., & Bodenmann, G. (2020). Interventions for couples. *Annual Review of Clinical Psychology, 16,* 99–123.

Bradford, A. B., Hawkins, A. J., & Acker, J. (2015). If we build it, they will come: Exploring policy and practice implications of public support for couple and relationship education for lower income and relationally distressed couples. *Family Process, 54,* 639–654.

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process, 59,* 974–988.

Chambers, A. L. (2019). African American couples in the 21st century: Using integrative systemic therapy (IST) to translate science into practice. *Family Process, 58, 595–609.*

De Boer, K., Muir, S. D., Silva, S. S. M., Nedeljkovic, M., Seabrook, E., Thomas, N., & Meyer, D. (2021). Videoconferencing psychotherapy for couples and families: A systematic review. *Journal of Marital and Family Therapy, 47,* 259–288.

Doherty, W. J., & Harris, S. M. (2017). *Helping couples on the brink of divorce: Discernment counseling for troubled relationships.* Washington, DC: American Psychological Association.

Doss, B. D., Roddy, M. K., Wiebe, S. A., & Johnson, S. M. (2022). A review of the research during 2010–2019 on evidence-based treatments for couple relationship distress. *Journal of Marital and Family Therapy, 48,* 283–306.

Falicov, C. J. (2014). *Latino families in therapy* (2nd ed.). New York: Guilford Press.

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process, 55,* 423–442.

Fraenkel, P. (2009). The therapeutic palette: A guide to choice points in integrative couple therapy. *Clinical Social Work Journal, 37,* 234–247.

Goger, P., & Weersing, V. R. (2022). Family based treatment of anxiety disorders: A review of the literature (2010–2019). *Journal of Marital and Family Therapy, 48,* 107–128.

Goldman, R. N., & Greenberg, L. S. (2015). *Case formulation in emotion-focused therapy: Co-creating clinical maps for change.* Washington, DC: American Psychological Association.

Gottman, J., Gottman, J., & Shapiro, A. (2010). A new couples approach to interventions for the transition to parenthood. In M. S. Schulz, M. K. Pruett, P. K. Kerig, & R. D. Parke (Eds.), *Strengthening couple relationships for optimal child development: Lessons from research and intervention* (pp. 165–179). Washington, DC: American Psychological Association.

Gurman, A. S. (1978). Contemporary marital therapies: A critique and comparative analysis of psychoanalytic, behavioral and systems theory approaches. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy: Psychoanalytic, behavioral and systems theory perspectives* (pp. 445–566). New York: Brunner/Mazel.

Gurman, A. S., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process, 41,* 199–260.

Gurman, A. S., & Kniskern, D. P. (1978). Behavioral marriage therapy: II. Empirical perspective. *Family Process, 17,* 139–148.

Gurman, A. S., & Kniskern, D. P. (Eds.). (1981). *Handbook of family therapy.* New York: Brunner/Mazel.

Hardy, K. V., & Bobes, T. (2017). *Promoting cultural sensitivity in supervision: A manual for practitioners.* New York: Routledge.

Hardy, N. R., Maier, C. A., & Gregson, T. J. (2021). Couple teletherapy in the era of COVID-19: Experiences and recommendations. *Journal of Marital and Family Therapy, 47,* 225–243.

Hertlein, K. M., Drude, K. P., Hilty, D. M., & Maheu, M. M. (2021). Toward proficiency in telebehavioral health: Applying interprofessional competencies in couple and family therapy. *Journal of Marital and Family Therapy, 47,* 359–374.

Hogue, A., Schumm, J. A., MacLean, A., & Bobek, M. (2022). Couple and family therapy for substance use disorders: Evidence-based update 2010–2019. *Journal of Marital and Family Therapy, 48,* 178–203.

Jacobson, N. S., & Gurman, A. S. (Eds.). (1986). *Clinical handbook of marital therapy.* New York: Guilford Press.

Kelly, S., Jérémie-Brink, G., Chambers, A. L., & Smith-Bynum, M. A. (2020). The Black Lives Matter movement: A call to action for couple and family therapists. *Family Process, 59,* 1374–1388.

Kelly, S., Wesley, K. C., Maynigo, T. P., Omar, Y., Clark, S. M., & Humphrey, S. C. (2019). Principle-based integrative therapy with couples: Theory and a case example. *Family Process, 58,* 532–549.

Kreider, R. M., & Ellis, R. (2011). *Number, timing, and duration of marriages and divorces: 2009* (Current Population Reports No. P70–125). Washington, DC: U.S. Census Bureau.

Lazarus, A. A. (1989). Why I am an eclectic (not an integrationist). *British Journal of Guidance and Counselling, 17,* 248–258.

Lebow, J. L. (1997). The integrative revolution in couple and family therapy. *Family Process, 36,* 1–17.

Lebow, J. L. (2014). *Couple and family therapy: An integrative map of the territory.* Washington, DC: American Psychological Association.

Lebow, J. L., Chambers, A. L., Christensen, A., & Johnson, S. M. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy, 38,* 145–168.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2,* 53–70.

McShall, J. R., & Johnson, M. D. (2015). The association between relationship distress and psychopathology is consistent across racial and ethnic groups. *Journal of Abnormal Psychology, 124,* 226–231.

Michaelson, R. B. (1963). *An analysis of the changing focus of marriage counseling.* Unpublished dissertation, University of Southern California, Los Angeles, CA.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice.* New York: Norton.

Norcross, J. C., Pfund, R. A., & Prochaska, J. O. (2013). Psychotherapy in 2022: A Delphi poll on its future. *Professional Psychology: Research and Practice, 44,* 363–370.

Organization of Economic Cooperation and Development. (2011). *Marriage and divorce rates.* www.oecd.org/els/family/sf_3_1_marriage_and_divorce_rates.pdf.

Orlinsky, D. E., & Ronnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC: American Psychological Association.

Roddy, M. K., Nowlan, K. M., Doss, B. D., & Christensen, A. (2016). Integrative behavioral couple therapy: Theoretical background, empirical research, and dissemination. *Family Process, 55,* 408–422.

Roddy, M. K., Walsh, L. M., Rothman, K., Hatch, S. G., & Doss, B. D. (2020). Meta-analysis of couple therapy: Effects across outcomes, designs, timeframes, and other moderators. *Journal of Consulting and Clinical Psychology, 88,* 583–596.

Sager, C. J. (1976). *Marriage contracts and couple therapy: Hidden forces in intimate relationships.* New York: Brunner/Mazel.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy, 29,* 547–570.

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 73,* 6–14.

Shields, C. G., Finley, M. A., Chawla, N., & Meadors, W. P. (2012). Couple and family interventions in health problems. *Journal of Marital and Family Therapy, 38,* 265–280.

Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couples therapy. *Clinical Psychology: Science and Practice, 6,* 348–365.

Snyder, D. K., & Balderrama-Durbin, C. (2020). Current status and challenges in systemic family therapy with couples. In K. Wampler, R. Miller, R. Seedall, L. McWey, A. Blow, M. Rastogi, & R. Singh (Eds.), *Handbook of systemic family therapy: Vol. 3* (pp. 3–25). New York: Wiley.

Snyder, D. K., Wills, R. M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A four-year follow-up study. *Journal of Consulting and Clinical Psychology, 59,* 138–141.

Swindle, R., Heller, K., Pescosolido, B., & Kikuzawa, S. (2000). Responses to nervous breakdowns in America over a 40-year period: Mental health policy implications. *American Psychologist, 55,* 740–749.

Waite, L. J., & Gallagher, M. (2000). *The case for marriage: Why married people are happier, healthier, and better off financially.* New York: Doubleday.

Whitaker, C. A. (1958). Psychotherapy with couples. *American Journal of Psychotherapy, 12,* 18–23.

Whitaker, C. A., & Keith, D. V. (1981). Symbolic–experiential family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 1, pp. 187–224). New York: Brunner/Mazel.

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process, 55,* 390–407.

CHAPTER 2

Couple Assessment

Douglas K. Snyder and Christina Balderrama-Durbin

We believe in individual differences. People vary in countless and dramatic ways in how they experience or express emotions, their values and beliefs about relationships, the families and cultures in which they grew up, and the social contexts in which they now find themselves. These individual differences recursively interact with how partners engage with each other. Every couple's unique constellation of challenges and strengths reflects critical variation at each level of the broader ecological system—beginning with the individual partners, their relationship with one another as well as with any children, interactions with extended families, and their broader socioecological context. Understanding individual differences at every level is essential for selecting, tailoring, and sequencing couple therapy interventions in an effective manner.

Throughout this *Handbook*, nearly every chapter includes a discussion of clinical assessment, in keeping with chapter guidelines proposed by the editors. Those discussions are inherently influenced and constrained by the specific model or application featured in that chapter—either in content (e.g., methods related to a specific disorder or issue), theoretical approach (e.g., methods emphasizing a cognitive-behavioral vs. emotion-focused orientation), or philosophical stance (e.g., use of standardized measures vs. reliance on partners' unique narratives). By contrast, in this chapter we present a transtheoretical view of couple assessment that incorporates many of the concepts and methods of assessing couples described in subsequent chapters but transcends specific models or applications by providing an overarching framework that aims to address the following key issues in conducting couple therapy:

- What do we need to know about individual partners, their relationship, and the broader socioecological context of their lives?
- How can we optimally obtain this information? What and how do we ask? What and how do we observe?
- How do we engage partners in a collaborative process for obtaining, integrating, and then applying information toward therapy goals they identify as relevant or essential?

We first articulate a multifaceted, multilevel conceptual model for directing and organizing assessment strategies and findings relevant to couples. Clarifying how to think about domains and levels of a couple's relationship and understanding *what* to assess necessarily precede consideration of any specific assessment methods or evaluation techniques. Second, we describe general clinical guidelines and specific strategies regarding *how* to assess couples. We initially emphasize the clinical interview and the clinician as a measurement instrument and only then turn to standardized measures for evaluating couple distress and well-being. This chapter emphasizes a conceptual framework and guiding principles rather than a technical review of the multitude of specific interview, observational, or self-report techniques. Third, we discuss both challenges and opportunities of couple assessment across diverse or understudied groups. Finally, we illustrate the importance of integrating couple assessment with treatment planning and evaluation with a clinical case emphasizing a collaborative, therapeutic approach.

BACKGROUND

There is little that is not relevant to assessing couples. Most obvious are the partners' levels of overall satisfaction or distress regarding their relationship. Related to this at the couple level are the dyadic behaviors, quality of affect, and patterning of expectancies and related cognitions that define their relationship. Relationship constructs emerge, in part, from the interaction of individual characteristics that both partners bring to their exchanges. At a broader level, a couple's relationship influences and is influenced by persons outside the dyad, including children, families of origin, and social or community support or stressors. Although comprehensive assessment of individuals theoretically entails evaluation across a similar breadth of domains and levels of the psychosocial ecological system, the interpersonal context of presenting concerns is rarely as compelling as that with couples and families.

The Conceptual Model

Snyder, Cavell, Heffer, and Mangrum (1995) proposed a comprehensive model for directing and organizing assessment strategies for couples and families. The model proposes five construct domains: (1) cognitive, (2) affective, (3) behavioral and control, (4) structural/developmental, and (5) communication and interpersonal. Constructs relevant to each of these domains can be assessed at each of the multiple levels comprising the psychosocial system in which the couple or family functions. The model posits five distinct levels of this system: (1) individuals, (2) dyads, (3) the nuclear family, (4) the extended family and related social systems, and (5) the community and cultural systems. Each of the five target domains may be assessed with varying degrees of relevance and specificity across each of the five system levels using both formal and informal assessment approaches to self-report and observational methods. This model emphasizes the fluid nature of individual as well as system functioning by linking structural with developmental processes. It also presumes that individual members of a couple or family recursively influence, and are influenced by, the broader social system.

Constructs across Domains and Levels

Table 2.1 provides a modest sampling of specific constructs relevant to each domain at each system level. Our intent is not to attempt a comprehensive list of all constructs relevant to individual, couple, or broader systemic functioning but instead to offer a way of thinking about how specific constructs map onto different domains of functioning and generalize across individual, couple or family, and broader system levels.

For example, important constructs within the cognitive domain at the individual level include general cognitive resources underlying the ability to understand and apply concepts, and the capacity for self-reflection and insight. A second cognitive dimension involves individuals' self-views, including self-efficacy and the extent to which individuals regard themselves as contributing to their own distress and able to effect change. Cognitive constructs at the dyadic level emphasize views toward the relationship and include (1) assumptions that individuals make about how this relationship or relationships in general function, (2) standards for how a relationship or members of a relationship *ought* to function, (3) selective attention to relationship events congruent with existing belief systems, (4) expectancies regarding the course and impact of individuals' own and others' behaviors in a relationship, and (5) attributions regarding the causes for relationship events (see also Chapter 3 on cognitive-behavioral couple therapy, in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade). Similar to standards at the dyadic level are values at the family level, and norms or mores at the cultural level. For example, families differ in the extent to which they espouse intellectual and aesthetic endeavors, recreational activity, religious or moral pursuits, personal achievement, and independence.

Persons vary in their general range of affective or emotional intensity and the extent to which affect persists across time and situations. They also vary in their ability to access, identify, and regulate emotions (Snyder, Simpson, & Hughes, 2006). Affective dimensions of cohesion, expressiveness, satisfaction, and commitment have all been identified in the dyadic relationship litera-

TABLE 2.1. Sample Assessment Constructs across Domains and Levels of Couple and Family Functioning

	Individual	Dyad (couple, parent–child)	Nuclear family system	Extended system (family of origin, friends)	Culture/ community
Cognitive	Intelligence; memory functions; thought content; thought quality; analytic skills; cognitive distortions; schemas; capacity for self-reflection and insight.	Cognitions regarding self and other in relationship; expectancies, attributions, attentional biases, and goals in the relationship.	Shared or co-constructed meanings within the system; family ideology or paradigm; thought sequences between members contributing to family functioning.	Intergenerational patterns of thinking and believing; co-constructed meaning shared by therapist and family or other significant friends or family.	Prevailing societal and cultural beliefs and attitudes; ways of thinking associated with particular religious or ethnic groups that are germane to the family or individual.
Affective	Mood; affective range, intensity, and valence; emotional lability.	Predominant emotional themes or patterns in the relationship; cohesion; range of emotional expression; commitment and satisfaction in the relationship; emotional content during conflict; acceptance and forgiveness.	Family emotional themes of fear, shame, guilt, or rejection; system properties of cohesion or emotional disaffection; emotional atmosphere in the home—including humor and joy as well as conflict and hostility.	Emotional themes and patterns in extended system; intergenerational emotional legacies; patterns of fusion or differentiation across generations.	Prevailing emotional sentiment in the community, culture, and society; cultural norms and mores regarding the expression of emotion.
Behavioral	Capacity for self-control; impulsivity; aggressiveness; capacity to defer gratification. Overall energy and drive.	Recursive behavioral sequences displayed in the relationship; behavioral repertoire; reinforcement contingencies; strategies used to control other’s behavior.	Repetitive behavioral patterns or sequences used to influence family structure and power; shared recreation and other pleasant activities.	Behavioral patterns displayed by the extended system (significant friends, family of origin, therapist) used to influence the structure and behaviors of the extended system.	Cultural norms and mores of behavior; behaviors which are prescribed or proscribed by the larger society.
Interpersonal/ communication	Characteristic ways of communicating and interacting across relationships or personality (e.g., shy, gregarious, narcissistic, dependent, controlling, avoidant).	Quality and frequency of the dyad’s communication; speaking and listening skills; how couples share information, express feelings, and resolve conflict.	Information flow in the family system; paradoxical messages; family system boundaries, hierarchy, and organization; how the family system uses information regarding its own functioning; family decision-making strategies.	Degree to which information is shared with and received from significant others outside the nuclear family system or dyad; the permeability of boundaries and the degree to which the family or couple is receptive to outside influences.	Information that is communicated to the family or individual by the community or culture in which they live; how the family or individual communicates their needs and mobilizes resources.

(*continued*)

TABLE 2.1. (*continued*)

	Individual	Dyad (couple, parent–child)	Nuclear family system	Extended system (family of origin, friends)	Culture/ community
Structural/ developmental	All aspects of physiological and psychosocial development; personal history that influences current functioning; intrapersonal consistency of cognitions, affect, and behavior.	History of the relationship and how it has evolved over time; congruence of partners' cognitions, affect, and behavior.	Changes in the family system over time; current stage in the family life cycle; congruence in needs, beliefs, and behaviors across family members.	Developmental changes across generations; significant historical events influencing current system functioning (e.g., death, illness, divorce, abuse); congruence of beliefs and values across extended social support systems.	The cultural and political history of the society in which the family or individual lives; current political and economic changes; congruence of the individual's or couple's values with those of the larger community.

ture. Indeed, relationship satisfaction comprises the most widely investigated dimension of intimate dyads. More recently, both clinicians and researchers have addressed the constructs of acceptance and forgiveness in relationships—that is, the ability to suspend the hurt or anger associated with relationship conflicts (Gordon et al., 2019). Affective constructs have been described in the broader family level as well. For example, families often convey a collective mood, varying along dimensions of optimism, contentment, anger, worry, guilt, or despair. High levels of emotional connectedness and social support at the extended family and community levels provide a vital resource for couples. An important focus of assessment involves the extent to which family members have balanced developmental tasks of differentiating from extended systems, while retaining the ability to draw on the support functions of those systems. Additionally, experiences of adversity and trauma including intergenerational trauma or collective historical experiences of trauma must be considered because they can impact affective experiences of pain and mistrust, as well as healing and resilience at every level.

In assessing behavior and control at an individual level, capacity for self-control reflects the extent to which partners can defer self-gratification for the sake of the other or for their relationship. At the dyadic level, the means by which partners struggle to influence each other and the models adopted for decision making (e.g., unilateral vs. collaborative) comprise key dimensions in a couple's relationship. Couples may use different decision-making models across different aspects of family life, or across different subsystems within the family; thus, assessment should differentiate between typical decision-making strategies and their variability across situations. Also central to behavioral control at the dyadic level is the management of conflict and aggression. Extended systems at the family or community level exert influence or control to the degree that they make the availability of desired resources contingent on one or more family members' behavior. Couples frequently experience conflict when partners differ in their perception or tolerance of control exerted by others, outside their own relationship.

Communication difficulties are a common reason couples enter into couple therapy. Most frequently studied among dyads is the ability to resolve conflicts and negotiate mutually acceptable solutions; also emphasized are the abilities to express and respond to feelings constructively. Although communication typically is viewed as involving two or more persons, consistency in a person's relational style across diverse topics and situations with others points to an important individual source of communication behaviors. Communication may be direct or indirect, deliberate or haphazard, constructive or destructive. Similar to individuals and dyads, conflict resolution behaviors and the expression of both positive and negative feelings emerge as important components of communication at the family system level as well. Critical to couples' functioning are the means by which partners attempt to negotiate conflict resolution with members of the extended family, and their strategies for securing social support and mobilizing community resources.

Structural considerations include intrapersonal consistency across cognitive, affective, and behavioral domains (e.g., Does the individual behave in a manner congruent with his or her beliefs and feelings?), as well as interpersonal congruence or discrepancies between partners across these same domains. Also relevant are critical events in partners' developmental histories, as well as the course of their relationship. Both the likelihood of specific conflicts, as well as their interpretation and impact, may vary as a function of partners' ages, as well as the stage or duration of the relationship. For example, Haynes and colleagues (1992) found that parenting, extended family, and sex were less strongly related to marital satisfaction, whereas health of the spouse and other forms of affection were more important factors in marital satisfaction in older (i.e., over 55 years) compared to younger couples. Changes in a couple's interactions often reflect the modification of norms, roles, and other characteristics as the relationship adapts or fails to adapt to new challenges over time.

Also operating primarily at the individual level, but cutting across domains of functioning, are comorbid conditions involving disorders of physical or mental health. In a U.S. population-based survey of 2,213 married adults, Whisman (2007) found that marital distress was associated with (1) broad-band classifications of anxiety, mood, and substance use disorders and (2) 10 of 11 narrow-band specific disorders within those broad classes, with the strongest associations obtained between marital distress and bipolar disorder, alcohol use disorders, and generalized anxiety disorder. Mental or physical health problems can have a profound negative effect on relationship functioning through myriad behaviors or changes in circumstances that alter interactions between partners. Similarly, physical health disorders may negatively impact couples' relationship through caregiver strain or reduced opportunities for positive exchange, and couple distress may disrupt or constrain various health-oriented interventions (see also Ruddy & McDaniel, Chapter 28, in this volume). Hence, when assessing couples with coexisting physical or mental health concerns, the clinician needs to evaluate how individual disorders of either partner potentially derive from, contribute to, or perpetuate the couple's relational challenges.

How one approaches the task of assessing couples across the domains and levels of functioning defined by this conceptual model varies according to purposes of the evaluation, resources of time and instrumentation, willingness of partners to participate in various assessment tasks, and theoretical orientation of the clinician. In the section that follows, we offer general guidelines and strategies for how to assess couples, bearing in mind that decisions regarding the specific process and content of the assessment must be tailored to the unique needs of the couple, the objectives of the evaluation, as well as the theoretical orientation of the therapist.

THE PRACTICE OF COUPLE ASSESSMENT

General Guidelines

How should therapists choose among the diverse strategies available for assessing couples? The following criteria are general recommendations to guide the assessment process:

- Assessment foci should progress from broad to narrow—first identifying relationship concerns at the broader construct level, then examining more specific facets of couple distress and its correlates using a finer-grained analysis.

- An initial semistructured interview allows the therapist to survey a wide range of potential issues, while retaining the flexibility to explore specific concerns of the couple in a more detailed manner. The clinical interview and informal observation of couples' communication should be followed by a self-report strategy that differentiates among levels and sources of relationship distress. Areas of individual or relational distress revealed by these approaches can then be assessed further using structured observations or narrow-band self-report techniques with clear evidence of reliability, validity, and clinical utility.

- Within clinical settings, certain domains (communication, aggression, substance use, affective disorders, emotional or physical involvement with an outside person) should always be assessed with every couple. Beyond this, specific assessment methods should be linked to theory and an explicit intervention model.

- Couple assessment should integrate findings across multiple assessment methods and, at the same time, be parsimonious. This can be facilitated by choosing evaluation strategies and modalities that complement each other and by following a sequential approach that uses increasingly narrow-band measures to target problem areas that have been identified by other assessment techniques.

- Therapists should be familiar with clinically important aspects of individuals' culture while recognizing that cultural stereotypes are not necessarily valid for any given individual or couple. Similarly, clinicians should integrate data from multiple assessment methods and measures in a culturally sensitive manner.

- Couple therapists should pursue collateral assessment data from other professionals when relevant to any comorbid mental or physical health conditions (e.g., therapists treating an individual partner for a mood or substance-use disorder, physicians involved in treating medical issues, or school personnel with knowledge of a child's or adolescent's difficulties impacting the couple relationship).

- Finally, assessment should continue throughout therapy—including moment-to-moment interactions between partners and between the couple and therapist—to evaluate the outcomes of specific interventions and to inform the selection and tailoring of subsequent interventions.

The Role of the Therapist

We subscribe to principles of therapeutic assessment (Finn & Tonsager, 1997) in which the couple is included from the outset in the formulation of issues to be addressed and in a subsequent discussion of initial assessment findings. When adopting this approach, the couple therapist offers expertise regarding potentially relevant constructs and assessment strategies but regards the partners as experts on specific constructs germane to their own concerns as well as the implications of assessment findings for their own unique circumstances. The therapist joins as a participant-observer in the assessment process, sharing and exploring initial impressions as an opportunity for dialogue with the couple. Partners are invited to offer their own perspectives on how initial assessment findings align or not with their own views of their relationship, and to use these in co-creating a formulation of their challenges and strengths. The therapist then helps the couple to consider this formulation in articulating initial treatment goals and proposes a tentative framework or "road map" outlining a therapeutic process aimed at attaining these. When implemented successfully, therapeutic assessment provides partners with a new way of thinking and feeling about themselves and their relationship and encourages a shift from "what's wrong" to "how can we make this better."

The Structure of Assessment

Initial Interview

The clinical interview remains the most important tool in couple assessment. Various formats for organizing and conducting an initial assessment interview with couples have been proposed, as reflected in chapters in this *Handbook*. For example, some authors propose a four-part evaluation that includes an initial meeting with the couple followed by separate sessions with each partner individually, then an additional conjoint meeting with the partners. Although this format potentially permits greater exploration of relationship and individual concerns, it has several potential drawbacks. The length of this assessment may not be feasible in many managed care environments that limit the number of treatment sessions. Couples in crisis may also become discouraged if the pacing of assessment requires several weeks before initial interventions are undertaken to reduce immediate distress. Finally, individual assessment sessions for some couples may elicit unilateral disclosure of secrets, engender imbalances in the therapist's alliance with each partner or partners' fears of such imbalances, and subsequently detract from a collaborative therapeutic alliance.

We prefer an extended initial assessment interview lasting about 1½ to 2 hours, in which the following goals are stated at the outset: (1) first getting to know each partner as an individual, separate from their relationship; (2) learning about the couple's history, including current relationship difficulties, their development, and previous efforts to address these; and (3) reaching an informed decision together about whether to proceed with further assessment and couple therapy and, if so, discussing respective expectations.

GETTING TO KNOW THE INDIVIDUALS

Each partner should be interviewed in turn to obtain information about age, education, current occupation if working outside the home, employment history, religious beliefs/practices, and other cultural considerations. To what extent does the individual's work contribute to his or her stress or sense of well-being? Information is also obtained regarding physical health, and both current and previous medical and psychological treatment. If the couple was previously in therapy, what were the primary issues addressed at that time? What worked well in that treatment, what worked less well, and how do previous experiences in therapy influence the individuals' hopes, fears, or expectations about pursuing couple therapy now?

Also reviewed briefly are the structure and history of the families of origin. Are the individuals' birth parents still living and, if so, are they married? What are the first names and ages of siblings? How frequent and what type of contact do the individuals have with members of their families of origin, and how satisfying are these relationships? The therapist should also explore relevant adverse childhood experiences or difficulties (e.g., economic hardship; physical, emotional, or sexual abuse; witnessing violence between caregivers; experiences of discrimination) because these have been shown to adversely impact adult individual and relationship functioning (Cigrang et al., 2021; Dvir, Ford, Hill, & Frazier, 2015). The goal of these questions is not to obtain detailed family histories but, instead, to evaluate overall levels of intimacy or conflict in the families of origin, indicators of emotional or behavioral enmeshment or disengagement, models of emotional expressiveness and conflict resolution, appropriateness and clarity of boundaries, and standards or expectations regarding authority, autonomy, fidelity, and similar themes.

Similar information should be sought regarding previous marriages or similar relationships. For each, what were the ages of partners when they entered the relationship? How long did the relationship last, and how did it end? Were there children by that relationship and, if so, what are their names, ages, and current living arrangements? How much and what kinds of contact does each individual have with his or her former partner(s) and any children from those relationships, and how satisfying or conflicted are these relationships? Who else does the therapist need to know about relative to impact on the individual or couple's relationship (e.g., current or previous affair partner)?

Each partner should be asked questions to screen for factors that may potentially contribute to crises later in the therapy. These include questions concerning (1) history and current patterns of alcohol and other substance use, (2) history or potential for aggressive behavior toward oneself or others, and (3) current or possible future involvement in legal proceedings. In broaching these domains, partners can be reassured of the therapist's concern about times when couple therapy becomes difficult and may exacerbate distress on an intermediate basis, generating a need to evaluate ahead of time additional stressors that may compromise efforts to contain that distress.

Finally, each partner should be asked, "What else should I know about you that I've neglected to ask, or that you'd like me to know about you because of its importance to you personally?"

LEARNING ABOUT THE COUPLE'S HISTORY AND CURRENT DIFFICULTIES

Partners come to an initial interview primed to talk about their relationship difficulties, bare their heartaches and, often, explain why the other partner is primarily at fault. Beginning the interview with an emphasis on getting to know each individual helps to counteract this tendency. So too does helping partners to begin talking about their relationship in a more positive manner—recollecting how they met, courted, decided to enter a committed relationship and, hopefully, enjoyed earlier times in their relationship before deterioration or conflict set in. Inquiries for promoting this include "How did you meet, and what characteristics of your partner did you find especially attractive?"; "What were the circumstances that led to your decision to become a couple?"; and "What are your best memories from early in your relationship?"

The therapist can highlight the transition to discussing the couple's challenges with this directive: "Tell me why you're here." Couples invariably recognize this prompt to describe their current relationship difficulties and their decision to seek assistance. Because communication difficulties are frequently cited as the reason for seeking therapy, and because this response reveals little about the specific nature of communication deficits or specific domains in which communication difficulties are experienced, specific questions need to delineate the precise nature of relationship distress, its evolution, and previous efforts to address these difficulties. The therapist can allow either partner to begin but should ensure that both partners contribute to the discussion.

How do the partners define their primary difficulties? Who has defined the problem? Is one partner more involved in or more distressed by the problem than the other and, if so, why? What does each partner identify as the primary contributing factors to the current struggles? How do partners agree or disagree on the definition and understanding of their difficulties? What experiences and discussions have led them to define their relationship problems in this way? What solutions have they tried in the past, and how did they decide to seek outside assistance at this time? Finally—and perhaps most importantly—what does each individual believe he or she would need to do to promote positive change in the relationship?

REACHING AN INFORMED DECISION ABOUT COUPLE THERAPY

The initial assessment interview with a couple—whether conducted in one or multiple sessions—should conclude with a brief formulation of the couple's concerns that includes both individual and relationship resources the couple can mobilize and direct toward strengthening the couple bond and reducing relationship distress. While advocating such a formulation within a collaborative assessment process, we recognize that different models of couple therapy vary in how they view and manage such feedback. For example, more behaviorally oriented models and applications may propose a formulation that emphasizes presenting difficulties and offers tentative hypotheses regarding predisposing, precipitating, and perpetuating causal mechanisms potentially linked to specific intervention strategies. In contrast, poststructural models might focus on couple strengths rather than presenting concerns (e.g., a solution-focused approach) or may defer offering the therapist's formulation in favor of fostering partners' own formulations (e.g., a narrative approach). However, an initial formulation provided in a collaborative (rather than hierarchical) manner serves to communicate what the therapist has heard (and invites corrective feedback), can be therapeutic by contextualizing (and often normalizing) partners' concerns, organizes partners' experiences in a more integrative and synthetic manner—thus reducing anxiety from overwhelming stress that may seem difficult to understand or manage, and explicitly offers hypotheses about possible paths forward that may serve to instill partners' shared hope.

It is rare that *no* redeeming features of a relationship can be identified in the initial interview, or that individual or relational characteristics are so irreparably toxic as to preclude encouragement of further assessment aimed toward an initial trial of four to six sessions of couple therapy. Exceptions might include instances of sexual or physical abuse by an unremorseful partner or severe substance abuse, mandating intensive individual treatment before couple therapy can be a viable alternative or adjunctive intervention.

Couples may be encouraged by offering tentative formulations that reframe existing struggles in more benevolent terms promoting change. For example, to what extent can the partners be helped to recognize and draw comfort from their similarities and to relabel differences as opportunities for growth or stimulation? Can role shifts associated with modal developmental changes in the family be "normalized" and ways be found to compensate without the current level of negative attributions and subjective cost?

Finally, therapists should also assess each individual's expectations regarding his or her own responsibilities and readiness for change, expectations for their partner's change, as well as anticipated or desired roles of the therapist. Ground rules regarding attendance by one or both partners at each session, limits to verbal aggression, confidentiality, and so forth, are likely to vary as a function of treatment modality and individual differences in therapist training, and must be conveyed clearly to both partners (see also Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen).

ADDITIONAL CONSIDERATIONS IN CONDUCTING THE CLINICAL INTERVIEW

Beyond considerations of interview content, there are equally important aspects of *process* to consider. Foremost among these are challenges in managing the intense negativity that some couples bring to the initial consultation. Even experienced therapists can struggle with balancing their efforts to help couples regulate their intense feelings with efforts to promote an initial collaborative relationship with both partners. Aspiring couple therapists need to resist their own discomfort with partners' overt anger or their reluctance to interrupt negative escalations. Instead, a critical intervention involves gently but firmly disrupting spiraling angry exchanges with statements such as this:

> "Let me pause you for a moment" [and repeating that as often as necessary in a soft tone until you have both partners' attention]. "I know this is difficult, and that's why you've come to me for assistance. It's important that we not use our time here only to do what you're already doing on your own outside of here. Let me try to help guide you through this—even if that means that sometimes I'll need to interrupt or pause you when the conversation gets derailed, okay?"

Sometimes, rather than spiraling negativity, the couple therapist observes pronounced disengagement in one of the partners who may have agreed to the initial couple consultation only reluctantly—for example, in response to the other partner threatening to end the relationship. In such cases, acknowledging that partner's willingness to "show up" is important—along with an explicit statement that participation in the initial interview implies no agreement or further obligation of that partner to additional sessions. For example:

> "Miguel—you've shown up today even though my sense is that couple therapy wasn't something you initially favored. Showing up and participating anyway reflects a kind of strength in character—so thank you for that. I don't presume whether we'll meet again or not after today—and that's something the three of us should decide together before we stop. Would that be okay with you?"

Separate from escalating hostility or disengagement, balancing contributions from both partners can be difficult when one is more verbal or dominant than the other. In such situations, the couple therapist needs to promote better balance by pausing the more active partner and then explicitly engaging the other one. For example:

> "Tony, let me pause you there for a moment. You're eager to share with me how you're experiencing things, and I appreciate that. But I know it's also important to you that Kim feel involved in the process—so let's create that space, okay?" [Then, turning to Kim . . .] "Kim, can you share your own perspectives?"

Finally, given the breadth of potential issues to be addressed implied by the multifaceted, multilevel conceptual model we've advocated, it can be challenging to discern which issues to cover—and at what levels of depth—in the initial interview. Articulating the three goals we've proposed (getting to know the individuals, their relationship, and reaching an initial decision about next steps) helps to define the overarching structure. Following a semistructured format and recognizing limitations to the initial consultation ahead of time also facilitate a process that balances breadth with depth of content. The therapist can acknowledge inherent constraints explicitly at the outset or during the interview if specific issues risk "taking over" and preventing other important information from becoming known. For example, the therapist might state:

> "Before we stop today, I'm hoping that I'll have a better understanding of the 'big picture'—knowing better who you each are, how your relationship came to be as it is right now, and how we might work together to help the relationship work better for both of you. There's a lot I won't know by the time we have to stop—and there might be ways that could feel frustrating to either one of you or even for me. But if we can get a sense of the big picture together, that will at least help guide us in figuring out next steps—where you want to head and how we might try to get there."

The general guidelines for couple assessment we described earlier also help with reaching decisions during the initial interview aimed at balancing breadth and depth: progressing from broad to narrow, emphasizing domains most relevant to partners' presenting concerns, and incorporating structured assessment measures targeting initial or emergent issues. That said, there are times when couples present with specific crises that inherently demand immediate and intensive assessment and intervention. Examples include suicidality or substance abuse, partner aggression, recent trauma or current medical crisis, recent discovery of infidelity, or some other situation involving the couple or a family member (e.g., a child or parent) that requires an intermediate decision by the conclusion of the initial consultation. In such circumstances, the therapist should engage the couple toward collaborative prioritizing of "what absolutely has to be decided before we stop today—and what can you otherwise 'tolerate or survive' until we can resume further discussion at another time."

Observational Assessment

Virtually all theories of relationship dysfunction and couple therapies emphasize communication deficits as a common pathway to relationship problems. Compared to nondistressed couples from the community, distressed couples (1) are more hostile; (2) start their conversations with greater hostility and maintain more hostility during the course of conversations; (3) are more likely to reciprocate and escalate the partner's hostility; (4) are less likely to edit their behavior during conflict, resulting in longer negative reciprocity loops; (5) emit less positive behavior; and (6) are more likely to show "demand ↔ withdraw" patterns, in which one partner engages in negative interaction (e.g., demanding, blaming, or accusing), while the other avoids and withdraws from the interaction (Heyman, 2001). Also relevant but less likely to be observed during structured communication tasks are generalized patterns of withdrawal or "stonewalling" (see Gottman & Gottman, Chapter 16, in this volume) in which one or both partners have fully disengaged and refuse to participate in relationship discussions.

Since the late 1960s, numerous coding systems have been developed for categorizing and analyzing couples' verbal and nonverbal communication behaviors. Comprehensive reviews of psychometric findings regarding these systems are provided elsewhere (e.g., Kerig & Baucom, 2004; Snyder, Heyman, Haynes, & Balderrama-Durbin, 2018). Although these systems vary widely, in general they target six major a priori classes of behaviors: (1) affect (e.g., humor, affection, anger, criticism, contempt, sadness, anxiety); (2) behavioral engagement (e.g., demands, pressures for change, withdrawal, avoidance); (3) general communication patterns (e.g., involvement, verbal and nonverbal negativity and positivity, information and problem description); (4) problem-solving (e.g., self-disclosure, validation, facilitation, interruption); (5) power (e.g., verbal aggression, coercion, attempts to control); and (6) support/intimacy (e.g., emotional and tangible support, attentiveness).

The specific instructions used to generate couples' observational data strongly influence both their representativeness and their clinical utility—but not necessarily in the same direction. For example, a couple reporting infrequent but intense disagreements about their sexual relationship might be directed to "replay" a memorable, high-conflict exchange in this domain, even though such exchanges may not characterize their relationship more generally. Alternatively, the partners might be asked to reenact their "best" discussions of their sexual disagreements, as well as their "typical" or "worst" discussions as a way of distinguishing between their optimal ability versus modal performance of communication behaviors.

At a fundamental level, all couple therapists regardless of theoretical orientation observe couple interactions—whether informally or by adopting a more structured approach. The risks of relying exclusively on informal observation include concerns, first, that during the initial consultation, partners may speak predominantly (or even exclusively) to the therapist and not to each other and, second, that the content and form of discussions observed may not represent typical problematic conversations experienced at home. By comparison, a risk of implementing a structured communication task during the initial consultation is that partners may experience it as intrusive, contrived, or not relevant to the specific concerns they wish to address.

Requesting an opportunity to observe "how you discuss issues at home" can be implemented in a sensitive and collaborative manner. Hence, we advocate that during the initial interview, the therapist invite the couple to have a 5- to 10-minute conversation regarding a topic of "moderate concern," while the therapist observes silently and without interruption. The therapist can say, "I want to understand how your conversations would typically go when I'm not here. I'm going to listen in, but I'll mostly look at the floor and will resist jumping in." If the discussion lasts only a few minutes, the therapist should initially refrain from entering into discussion to see whether the couple's conversation may resume. In observing the couple's discussion, the therapist should attend to the following issues: How does the conversation start? Does the level of anger escalate, and what happens when it does? Do the partners enter repetitive negative loops? Do partners label the other person or their communication process as the "problem"?

Following the observational assessment, the therapist may follow-up with these additional inquiries: Was this discussion typical of how they discuss disagreements at home? What do their disagreements look like during their very worst? Do their discussions differ when trying to resolve disagreements or reach decisions together around other issues? Do their behaviors differ when it is "partner *A*'s" topic versus "partner *B*'s"? Of course, efforts to resolve differences or reach decisions together are not the only kind of important conversations couples have. Hence, it can also be useful to observe discussions aimed at eliciting and providing emotional support. Toward this end, the therapist could ask one partner to describe a time when they were hurt or distressed by an interaction with someone outside the couple relationship and ask the other partner to respond "in a caring way"—and then reverse roles to observe emotional expressiveness and empathic responding in both directions.

Self-Report Methods

GENERAL CONSIDERATIONS

The rationale underlying self-report strategies in couple assessment is that such techniques (1) are relatively easy to administer, providing a wealth of information across a broad range of potentially relevant domains, (2) lend themselves to collection of large normative samples that serve as a reference or comparison group facilitating interpretation, (3) allow disclosure about events and subjective experiences that partners may be reluctant to discuss, and (4) provide important data concerning internal phenomena that are opaque to observational approaches, including values and attitudes, expectations and attributions, and satisfaction and commitment. However, the limitations of self-report measures also bear noting in that they (1) are susceptible to both deliberate and unconscious efforts to bias self- and other-presentation in either a favorable or unfavorable manner, (2) are vulnerable to individual differences in interpreting specific items and errors in recalling objective events, and (3) typically provide few fine-grained details concerning moment-to-moment interactions.

Decisions regarding which self-report measures to incorporate may flow in part from general guidelines described earlier—including (1) progressing from broad to more narrow foci based on initial findings, (2) always assessing certain domains because of their prevalence or impact when present, and (3) linking specific assessment methods to theory and an explicit intervention model. For example, in our own clinical practice, we routinely use the Marital Satisfaction Inventory—Revised (MSI-R; described later) because, in addition to assessing overall levels of couple distress, it elicits information regarding important relationship processes, specific common domains of couple difficulties, and potential contextual factors. Other measures may be incorporated when initial screening indicates specific issues or concerns warranting more detailed assessment (e.g., measures related to children, sexual functioning, or an individual problem involving alcohol misuse, depression, or cognitive impairment).

Self-report measures vary not only in their breadth versus specificity but also in their evidential basis and accessibility. As we note later in our discussion of psychometric considerations in the section on "Empirical Support," measures of couple functioning vary widely in the extent to which they provide even rudimentary evidence of their reliability or validity. Frequently (although exceptions exist) those measures with strong empirical foundations underlying their use and interpretation have been copyrighted and must be purchased from the developer or publisher. Adapting such measures (e.g., by selecting a subset of items or altering administration format) risks not only violating their copyright but also compromising the empirical bases of their reliability and validity. Regardless of whether selecting proprietary measures or those in the public domain, it is incumbent on the therapist to evaluate the psychometric underpinnings of the specific measure being considered and evidence regarding its appropriateness in light of the partners' age, ethnicity, gender identity, and other contextual considerations.

In the sections that follow, we briefly discuss considerations specific to self-report measures of relationship and individual functioning—and offer a small sampling of exemplars in each domain. More detailed descriptions of specific self-report methods relevant to couple assessment—including evaluations of their reliability and validity—have been provided elsewhere (e.g., Snyder et al., 2018) as well as throughout other chapters in this *Handbook*.

MEASURES OF RELATIONSHIP FUNCTIONING

Various compendia of couple and family assessment measures include over 1,000 such measures, often with little guidance regarding which techniques to select for which purposes. General guidelines described earlier emphasizing a parsimonious strategy progressing from broad to narrow foci and ensuring assessment of critical features such as aggression or other exclusionary criteria, inform our modest sampling of specific measures here.

Global Couple Distress. When a couple presents for couple therapy, assessing for the mere presence of couple distress will likely afford little, if any, incremental utility. More useful in that context are couple distress measures that facilitate normative comparisons to representative community and clinical samples. Historically, the Dyadic Adjustment Scale (DAS; Spanier, 1976) has been used for this purpose. We recommend a more recent set of scales developed from item response theory, the Couples Satisfaction Index (CSI; Funk & Rogge, 2007) with 32-, 16-, and 4-item versions. The brief, four-item CSI lends itself to repeated administrations throughout the course of therapy. The Marital Satisfaction Inventory—Revised (MSI-R; Snyder, 1997), described further below, includes a measure of global couple distress. A brief 10-item screener derived from that measure, the MSI brief form (MSI-B; Whisman, Snyder, & Beach, 2009) samples from five specific dimensions of relationship functioning and demonstrates high sensitivity and specificity to couple distress.

Communication and Aggression. Most models and specific applications of couple therapy advocate assessing specific patterns of communication, as well as verbal and physical aggression. For communication, a good measure is a seven-item short form of the Communication Patterns Questionnaire—Constructive Communication (CPQ-CC; Heavy, Larson, Zumtobel, & Christensen, 1996) reflecting both constructive and destructive partner behaviors during problem-solving discussions. A 20-item short form of the Conflict Tactics Scale—Revised (CTS2; Straus & Douglas, 2004) facilitates assessment of physical and psychological aggression. The MSI-R (Snyder, 1997) includes three scales assessing problem-solving communication, affective communication (emotional expressiveness and responsiveness), and aggression (including both verbal and physical components).

Model-Specific Measures. Various chapters in this *Handbook* recommend additional measures of relationship functioning targeting specific constructs germane to that model and meriting inclusion here. When pursuing interventions from any of the behavioral approaches (see Chapters 3–5), the 20-item Frequency and Acceptability of Partner Behavior Inventory (FAPBI; Doss & Christensen, 2006) aids in assessing specific positive and negative relationship behaviors. Other examples of model-specific constructs and related measures include attachment in emotionally focused therapy (a 12-item short form of the Experiences in Close Relationships Scale [ECR-S]; Wei, Russell, Mallinckrodt, & Vogel, 2007), and the family genogram (McGoldrick, Gerson, & Petry, 2008) for various intergenerational models of couple therapy. Particularly noteworthy is the suite of assessment tools linked to the Gottman method of couple therapy (see Gottman & Gottman, Chapter 16), including measures of affect and heart rate obtained directly from online video recording.

Multidimensional Assessment of Relationship Functioning. Widely used in both clinical and research settings is the MSI-R (Snyder, 1997), a 150-item inventory designed to identify both the nature and intensity of relationship distress in distinct areas of interaction. The MSI-R includes two validity scales, one global distress scale, and 10 specific scales assessing relationship concerns in areas such as affective and problem-solving communication, aggression, leisure time together, finances, the sexual relationship, role orientation, family of origin, and interactions regarding children. More than 40 years of research support the reliability and construct validity of the MSI-R scales. Studies suggest the potential utility of adaptations of the MSI-R for couples whose preferred language is other than English (e.g., Snyder et al., 2004) and for couples from marginalized sexual orientations (e.g., gay and lesbian couples; Means-Christensen, Snyder, & Negy, 2003). A computerized interpretive report for the MSI-R draws on actuarial validity data to provide descriptive comparisons across different domains, both within and between partners. An example of integrating findings from the MSI-R into initial assessment and treatment planning is included in the case illustration presented later in this chapter.

MEASURES OF INDIVIDUAL FUNCTIONING

Assessing partners' individual functioning is important from two respects: First, the well-established comorbidity between relationship distress and individual mental health problems (especially mood, anxiety, and substance misuse disorders) suggests the importance of screening for these disorders routinely with all couples; and second, various models of couple therapy and applications to specific populations or disorders call for assessment of relevant individual characteristics germane to those treatments. That said, given the potential for individuals to enter couple therapy with a heightened defensiveness regarding their own mental health functioning—in part because of prior pejorative attributions from their partner—assessment of individual functioning needs to be pursued thoughtfully within a collaborative assessment process.

Consistent with the guidelines to proceed from broad to narrow measures, a useful initial screening measure is the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), a 53-item adaptation of the Symptom Checklist-90—Revised (SCL-90-R). The BSI comprises nine primary symptom dimensions (e.g., somatization, interpersonal sensitivity, depression, and anxiety) and includes three global indices of distress. Scores reflecting concerns in any of these areas suggest further assessment with more detailed narrow-band measures. An alternative approach to the BSI is for the couple therapist to construct a 10- to 15-item measure composed of brief screeners in specific domains having high prevalence among distressed couples—for example, by including screening measures of posttraumatic stress disorder (Primary Care PTSD Screen [PC-PTSD]; Prins, 2003), depression (Patient Health Questionnaire–2 [PHQ-2]; Löwe, Kroenke, &

Gräfe, 2005), alcohol use (Alcohol Use Disorders Identification Test [AUDIT-C]; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998), and suicidality (Suicidal Behavior Questionnaire—Revised [SBQ-R]; Osman et al., 2001).

Specific models and applications of couple therapy included in this *Handbook* note additional measures of individual functioning relevant to that approach. Examples include the Multidimensional Psychological Flexibility Inventory (MPFI; Rolffs, Rogge, & Wilson, 2018) in acceptance and commitment therapy (see Chapter 5 by Lawrence, Cohn, & Allen); the Mentalization Questionnaire (Hausberg et al., 2012; see Chapter 8 by Bleiberg, Safier, & Fonagy); the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005) for therapy with older adult couples (see Chapter 20 by Knight); and the Child Behavior Checklist (CBCL; Achenbach, 2009) when working with parents of youth with emotional or behavioral difficulties (see Chapter 27 by Wymbs, Wymbs, & Canu). Because of the mutual, recursive influences of individual and relationship well-being, couple therapists should be equipped to select relevant, evidence-based measures across the broad spectrum of individual functioning tailored to unique concerns of the couple.

Ongoing Assessment and Therapeutic Decision Making

Regardless of their explicit stance as to whether "informed and thorough assessment of a relationship's strengths and challenges must precede intervention" (see Gottman & Gottman, Chapter 16) or that assessment is more "about 'generating experience' rather than 'gathering information' " (see Freedman & Combs, Chapter 10, in this volume), virtually all models of couple therapy emphasize that assessment and intervention are inextricably intertwined throughout the course of treatment. Assessment guides interventions, but the outcomes of those interventions—including moment-to-moment interactions between partners and between the couple and therapist in each session—provide evidence regarding the accuracy of the clinical formulation informed by the assessment. Every session generates new assessment data that recursively and iteratively inform therapeutic decision making—whether in the moment or in planning subsequent interventions in future sessions.

Some models of couple therapy advocate explicit screening at each session for overall relationship sentiment, critical incidents (e.g., partner aggression, self-harm, or substance misuse), and identification of "best" and "worst" events since the last session. Specific assessment strategies for conducting such screening may include a 5- to 10-item screener designed and tailored by the therapist to selected constructs or domains relevant to a given couple, or instead may draw on standard screeners described elsewhere in this *Handbook* (e.g., see Christensen et al., Chapter 4, and Gottman & Gottman, Chapter 16). Applications of couple therapy to specific relational issues or individual problems may also assess targeted domains at each session (e.g., a Breathalyzer test or alcohol saliva strip in couple therapy for alcohol problems, or a single-item screener for suicidality adapted from the SBQ-R in couple therapy for depression).

An alternative idiographic approach for assessing a couple's progress toward attaining individualized goals is the method of goal attainment scaling (GAS; see Whisman & Snyder, 1997). The GAS method involves first selecting and formulating specific treatment goals. The expected level of outcome is then specified for each goal, as well as the "somewhat more" and "somewhat less" than expected levels of outcome, and the "much more" and "much less" than expected levels of outcomes. Each level of outcome is assigned a value on a 5-point measurement scale that ranges from –2 for much less than expected level of outcome, to +2 for much more than expected level of outcome. At various junctures throughout treatment, partners rate the level of outcome for each goal at that moment, and these ratings can be used to continue or modify therapeutic strategies accordingly.

Finally, with the advantage of assessing a broad range of couple functioning across multiple domains, the MSI-R (Snyder, 1997) may be administered on repeated occasions during therapy to monitor progress in targeted areas or to identify alternative relationship issues warranting further intervention.

APPLICABILITY AND EMPIRICAL SUPPORT

Applicability

Although there are notable exceptions—including observational and self-report methods described earlier and many of those described in subsequent chapters in this *Handbook*—the reliability and validity of many couple assessment techniques have not been adequately established. Moreover, the psychometric characteristics of any assessment method—whether from interview, behavioral observation, or self-report questionnaire—are conditional on the specific population and purpose for which that assessment method was developed. Given that nearly all measures of couple distress were developed and evaluated using White, middle-class, married couples, their applicability for assessing ethnically diverse couples, gay and lesbian couples, and low-income couples is unknown.

Implications of these limitations for the couple therapist are several. First, even when using the most well-validated assessment methods, couple therapists will be well served by an attitude of humility—regarding assessment findings as tentative hypotheses to be considered collaboratively with both partners. Second, any discussion of assessment findings that involves comparisons of a given couple's data to findings from other groups (e.g., representative clinical or community samples) should be tempered by the realization that even the most "representative" comparison groups typically have wide within-group variability, such that normative data for that group may not reflect the unique characteristics of any constituent couple. Finally, couple therapists should view the construct of "culture" broadly. Although the construct of culture is often associated with ethnicity, culture can also subsume multiple interacting and overlapping dimensions of diversity and individual differences such as race, gender identity, religion/spirituality, sexual orientation, disability and economic status, age and occupation, and geographic location, among others.

Cultural considerations in couple assessment are important because culture can influence meaningful differences in couples' values, beliefs, expectations, goals, patterns of interaction, and the social and family context of the relationship, such as the role of a couple's extended family (Haynes, Kaholokula, & Tanaka-Marsumi, 2018; see also Chapter 12 on socioculturally attuned couple therapy, in this volume, by Knudson-Martin & Kim). A focus on culture highlights the multidimensional complexity and importance of differences across persons in couple assessment. Consider the likely cultural differences between an older, economically secure, suburban-dwelling, professional Asian American couple compared with a younger, economically disadvantaged, urban-dwelling, nonprofessional European American couple. This one example invokes five dimensions of culture—and as many as 120 possible combinations of aspects of culture. Hence, one can readily discern the challenges that therapists face in engaging in culturally sensitive couple assessment and in planning culturally sensitive interventions from the assessment data.

Empirical Support

The empirical basis of couple assessment warrants two considerations. The first involves the extent to which various assessment methods reliably and accurately reflect the targeted construct of relationship or individual functioning—that is, the *psychometric (evidence-based measurement) properties* of these methods. The second consideration involves the extent to which couple assessment positively impacts couple therapy process and outcome—that is, the *incremental utility* of assessment methods. We address each of these in turn.

Psychometric Considerations

Although psychometric features of any assessment method involve numerous considerations beyond the scope of this chapter, here we briefly note aspects of three: reliability, validity, and norms. *Reliability* refers to the consistency or reproducibility of the assessment data—whether across different items, occasions, or observers. Most assessment methods—particularly those specific to couple functioning—report reliability based on internal consistency (homogeneity or unidimensionality) of item content, indicated by alpha (α) or mean interitem correlation (r) coefficients. Such reliability indicators are easy to derive, but have limited relevance to constructs that are inherently complex or multidimensional (e.g., sexual satisfaction potentially related to the frequency, variety, and subjective impact of a range of physically intimate exchanges). More important, but less frequently reported, is the reliability of a measure across time. The temporal stability of measures is critical for appraising changes in observations or scores during therapy—that is, discerning whether such changes reflect random fluctuation or actual gains or deterioration during treatment. Interobserver reliability—or, in couple assessment, the agreement between partners' evaluations of their relationship—may be modest when the construct reflects subjective appraisals of satisfaction or distress but assume greater importance when targeting objective behaviors critical to relationship functioning (e.g., agreement in partners' reports of their own and each other's physical aggression).

Validity refers to the extent to which an assessment observation or score accurately reflects the targeted construct. Most measures of couple functioning rely on *content* validity—that is, the apparent relevance of the assessment procedure (e.g., observational task or scale item) to the construct (e.g., relationship satisfaction, conflict, or emotional intimacy). Therapists adopting various measures for couple assessment should exercise caution when selecting any specific methods based on their label or title because these may or may not accurately reflect the specific content comprising that method. For example, measures of global relationship sentiment may have divergent titles (e.g., quality, happiness, satisfaction, intimacy, accord—or their converse—distress, conflict, disaffection) but considerable overlap in item content and high covariation in their actual scores.

A more important facet of assessment methods is their *criterion-related* validity—that is, their association with theoretically congruent indicators of the target construct. Although many measures of relationship functioning purport criterion-related validity by virtue of their ability to distinguish between community and clinical samples, this constitutes weak evidence in that many measures of relationship functioning (e.g., measures of communication) may distinguish between contrasting samples by virtue of their association with overall couple distress rather than unique relatedness to the more specific target construct. Stronger evidence of criterion-related validity requires association of assessment findings with independently derived criteria of relationship functioning (e.g., clinician ratings from structured interviews or observational ratings based on empirically supported coding systems). Ideally, findings regarding criterion-related validity are accompanied by empirically derived cutoffs designating which levels of observations or scores identify specific risk levels for individual or relationship dysfunction.

Although reliable and valid measures may be interpreted from an idiographic perspective—that is, identifying someone as relatively higher or lower on some measure—interpretation from a nomothetic perspective, in which partners' scores are understood in part by their comparison to findings from some other group, requires that those groups be representative of the population to which generalizations will be made. For example, partners could benefit from knowing that their scores on a measure of general couple distress place them at the 85th percentile of distress compared to a representative community sample but only at the 35th percentile compared to a sample of clinically distressed couples beginning couple therapy.

With these considerations in mind, we conclude that measures of couple functioning vary widely in the extent to which they satisfy even rudimentary psychometric criteria. Few report temporal reliability, most rely on content- rather than criterion-related validity, and even the best measures have oversampled from White, middle-class, married couples when constructing norms. Hence, couple therapists should attend carefully to the psychometric considerations of any assessment methods they use, regard initial case formulations and treatment decisions as hypotheses to be informed and revised over the course of therapy and include partners in a collaborative process to evaluate assessment findings and their unique, specific implications for the couple.

Incremental Utility

Incremental utility regards the extent to which clinical assessment "makes a difference"—that is, whether the process of assessment and the findings derived from it impact treatment decisions and outcomes. At the most basic level, the decision to proceed with couple therapy requires determining through various assessment methods that neither partner exhibits an exclusionary criterion (e.g., psychoticism, severe substance addiction, or characterological partner violence). At a higher level, couple assessment identifies partner and relationship challenges and strengths that presumably influence initial treatment decisions about sequencing interventions (e.g., pursuing moderate-level issues identified by both partners). Assessing theoretically relevant constructs may inform decisions about which treatment models or strategies to pursue (e.g., attachment style relevant to emotionally focused couple therapy, capacities for mentalization relevant to mentalization-based couple therapy, or detailed family history relevant to various intergenerational models of couple therapy).

That said, to our knowledge there have been no differential treatment assignment studies comparing outcomes for couples randomly assigned to couple therapy model versus those assigned to specific couple treatments based on pretreatment assessment findings. There are, however, a small number of studies suggesting that ongoing assessment during couple therapy may benefit treatment outcome. Consistent with findings from studies of individual psychotherapy, Johnson and Talitman (1997) found that the quality of the alliance with the therapist predicted success in emotionally focused therapy (EFT) for couples. A more recent study of EFT indicated that whether the couple perceived the tasks of therapy as relevant significantly predicted treatment outcome (Linhof & Allan, 2019). Findings from a randomized clinical trial comparing cognitive- and integrative behavioral therapy indicated that a brief assessment of couple therapy progress at midtreatment detected a substantial proportion of couples who failed to benefit by the end of therapy (Halford et al., 2012). Further evidence comes from a randomized clinical trial of integrative systemic therapy (IST) examining the impact of therapists' use of assessment findings from the Systemic Therapy Inventory of Change (STIC; Pinsof, Zinbarg, Shimokawa, et al., 2015); results indicated that therapists were significantly more effective in treating individuals and couples when they incorporated the STIC system (Pinsof, Zinbarg, He, et al., 2015; as reported in Chapter 14, in this volume, by Breunlin, Russell, Chambers, & Solomon). Each of the Pinsof studies suggests that ongoing systematic assessment of relevant domains and collaborative discussion of assessment findings may enhance treatment outcomes.

Finally, it bears noting that relationship quality and outcomes of couple therapy are subjective phenomena ultimately defined by the two partners. Individuals may decide to end a relationship that, to an outsider, appears to be of higher quality than other relationships in which partners remain. (See further discussion of this issue in Chapter 21 on divorce, in this volume, by Lebow.) Hence, appraisals of the incremental utility of couple assessment—similar to considerations of couple therapy effectiveness more generally—need to consider individual as well as relationship criteria as evaluated by the respective partners.

CASE ILLUSTRATION

Background

Amaia and Matías were referred for couple therapy by Amaia's family physician after Amaia's responses to a brief screening measure of couple distress (the MSI-B) routinely administered in that medical practice indicated that she was experiencing moderate relationship distress potentially contributing to a variety of emotional and physical health concerns. Amaia, age 35, and Matías, age 31, had been married 9 years and had two sons, Luis and Erick, ages 8 and 3. This was the first marriage for both partners. Neither of them had previously received psychological services for individual or relationship issues.

Amaia reported an associate's degree from a 2-year community college, after which she entered the U.S. Air Force and was assigned to Security Forces. Her first few years of service mostly involved military police duties on base; however, she then incurred two deployments (12 months and 6 months across a 2-year period) to Iraq to assist with training Iraqi police—a high-risk mission that required patrolling communities with a high insurgent presence (see Cigrang et al., 2014, for research findings on the adverse impact of similar deployments on psychological and relationship health). Following her honorable discharge at the rank of Senior Airman, Amaia worked for several years as a private security officer on night shifts at a local mall. For the past 3 years, she has served as a law enforcement officer for the local police department—primarily on patrol duties but with occasional special assignment to investigative units. She described enjoying the occasional investigative work more than the street patrols, particularly after a spike in violent crime in one of the community's poorer neighborhoods over the past year.

Matías reported a bachelor's degree in information technology and had been employed by the local school district as an IT specialist for the past 9 years. He reported enjoying his work and the opportunities for additional training and career development it afforded. His consultations with classroom teachers at times frustrated him, and he described himself as "more of a problem-solver than a people-person." He aspired to obtain a district-level IT supervisor position within the next 5 years.

Amaia and Matías met during his last year in college and married shortly following his graduation. She was already serving in Security Forces at a nearby Air Force base but had not yet deployed. Their son, Luis, arrived in the first year of their marriage and, just as he reached age 2, Amaia had her first deployment to Iraq. Over the ensuing 2 years, Matías's mother provided care for Luis while Matías worked during the day. Their younger son, Erick, arrived several years later, at about the same time that Amaia began her position with the local police department. For the first 2 years, she requested night shifts so she could care for Erick during the day, but over the past year, with her transition to daytime assignments, Matías's mother again provided child care during the day.

Initial Interview

At the beginning of their initial interview, the couple therapist outlined the three primary goals of that first session: (1) getting to know a bit about each of the partners as individuals; (2) understanding their relationship—including its background and the concerns that brought them to this initial consultation; and (3) reaching a shared decision about whether to pursue additional assessment to inform a potential course of couple therapy. Both partners contributed to the interview, describing strengths and challenges of their relationship in a manner that was both balanced and mutually respectful.

The partners stated that they had been drawn to each other during their courtship by common values emphasizing community service, their ability to engage in warm and supportive conversations, a strong physical connection, and a shared vision of the kind of family they wanted to create together. They had eagerly anticipated their first son's arrival, although they acknowledged in retrospect that they hadn't understood the demands and intrusions that a newborn would bring to their marriage. When Amaia prepared to deploy during 2 years of Luis's early toddlerhood, she and Matías differed sharply about Luis's care. Amaia viewed her mother-in-law as a loving but stern person, with little patience or flexibility regarding a 2-year-old's testing of boundaries and emotional vicissitudes. She preferred a nearby day care center, but Matías had argued that the additional expense was burdensome and unnecessary. During the 6 months stateside between her two deployments, Amaia felt shut out and "overruled" by Matías and his mother, who claimed to have experience on their side regarding Luis's needs and development.

Over the past year, the strains in their relationship had multiplied. Their disagreements about how to deal with Luis's noncompliance and disruptive behavior at home grew more frequent and intense. Amaia was uncomfortable with Matías's harsh parenting style, and in response to his own angry outbursts she frequently withdrew into a different part of their home, taking their younger son Erick with her. When she challenged Matías regarding his own emotion dysregulation, their arguments escalated, with each blaming the other for their son's misbehaviors. Matías felt undermined by Amaia, and she in turn felt minimized and discounted. A pattern of unresolved disagreements followed by mutual retreat had taken over, with Matías feeling punished by Amaia when she avoided further interactions with him for days at a time.

Both partners reported increased stress from their respective work positions. Over the past year, Amaia had been assigned on multiple occasions to overnight patrols, and several high-risk incidents had triggered memories of her combat exposure in Iraq. She acknowledged "shutting down" at home following those occasions and having lower tolerance for tensions between her and Matías. Matías recognized her withdrawal and expressed an empathic awareness of residual trauma from Amaia's deployment experiences. He also described feeling pressured at work to elevate his IT presence in pursuit of promotion to a supervisory position. Matías was reluctant to discuss his work stresses with Amaia given her own struggles. Amaia expressed sadness that they had grown apart and felt constrained in sharing their respective struggles. She also expressed concern that Matías seemed to cope with their emotional distance in part by engaging in more alcohol use in the evenings, and she worried that he might do so on the nights when she was on patrol and he had sole responsibility for their sons.

Independent of these challenges, both partners reported sustaining an active and enjoyable sexual relationship. They described less snuggling or cuddling than they had enjoyed in the past, and fewer intimate conversations in bed together. Nevertheless, they both expressed gratitude that they had been able to preserve their physical closeness by periodically suspending other tensions or conflicts.

When asked how their interaction patterns compared to patterns in their families of origin, Amaia recalled that her father had been emotionally volatile and occasionally verbally aggressive toward her mother. Her mother had coped through passive compliance, and Amaia and her siblings had learned to avoid their father when he was upset. Matías reported that he had never witnessed his parents arguing between themselves. Similar to Amaia's father, his own father would frequently lapse into angry tirades toward Matías and his brothers. His mother never challenged his father in this regard and implemented her own stern approach toward discipline. Although acknowledging the tensions that had dominated their home, Matías attributed his own professional achievements in part to his parents' having enforced "high expectations and follow-through."

Observational Assessment

Their therapist invited Amaia and Matías to have a 5- to 10-minute conversation regarding a topic of "moderate concern" while she observed. After a brief exchange, the couple decided to discuss how to deal with occasions when they attempted to implement a time-out with Luis and he refused to comply. Their discussion began constructively as the partners reviewed their shared understanding of what a time-out should involve—for example, what behaviors warranted timeout, how to introduce the time-out to Luis, where he should go and for how long during the timeout, and so on. After several minutes the couple paused as though completing their discussion, but the therapist continued to observe silently. When the partners then resumed their discussion, it began to degrade quickly.

MATÍAS: Well, of course, that all sounds fine, and we've agreed on these things before. But that's not how it really goes, right?

AMAIA: What do you mean?

MATÍAS: It's not how it goes. When you're in charge and call a time-out, Luis whines and balks, and then you start a conversation with him about what he did and why it's wrong and why he needs to take a time-out—but he doesn't. There's just not any follow-through, and he knows it, and so he just waits you out and he wins.

AMAIA: Right—I try to stay calm and have a conversation. He's a little boy—not some pet animal you punish or reward with treats.

MATÍAS: I didn't say that . . .

AMAIA: (*interrupting*) And what do you do? You start yelling and threatening, and then you grab him by the arm and drag him to his room and threaten if he comes out you'll give him a whipping to remember. And you think that's okay?

MATÍAS: If you'd work with me on this, I wouldn't have to . . .

AMAIA: (*interrupting again*) How can I work with you? You start yelling and screaming, and I'm not comfortable even being around you, and I'm an adult and not even a little kid!

(*A long pause as both partners stare at the ground, waiting for the therapist to intervene.*)

THERAPIST: So that was helpful to me, to see how that sometimes goes between you. Was that a good example of what happens at home?

MATÍAS: Yeah, I guess so.

AMAIA: No—what happens at home is worse. We start yelling at each other and it gets ugly fast.

THERAPIST: Anything more than yelling—when it gets its worst?

AMAIA: You mean like hitting or something?

THERAPIST: Yes, or even just grabbing or restraining, or one of you blocking the other one's exit from the room.

AMAIA: Never hitting or shoving. Sometimes Matías will stand in the doorway to prevent me from going to a separate room.

MATÍAS: I know, you're right, and I'm sorry. But I just can't stand it when you walk away, knowing you might not talk to me for the next day or so.

(*Another pause. At this point both partners look more sad than angry.*)

THERAPIST: Gosh, it sounds like it must be just so painful for both of you. (*Amaia tears up, and Matías hangs his head even lower.*) Does it get like this when you're trying to discuss other topics to resolve a disagreement or reach some kind of decision together?

MATÍAS: Not always. Sometimes I think we do pretty well. Like we've been trying to figure out what to do with Amaia's car. It's got a lot of miles, and we have to decide whether to sink more money into repairs or shell out for a new one. We talked about it the other night—she thought we should go with the additional repairs for now. But I worry about her—I want her to be safe and to have a reliable car. And so we talked more, and then compromised on getting a good recent-model used car. And that felt really good.

AMAIA: When you said you were worried about me, that made all the difference for me. I was thinking about the finances—I know that's a concern for you.

THERAPIST: It sounds like you both handled that one really well—and you were able to express concerns for each other that made compromise easier. Are there times when your conversations are even more difficult than the one you had in here today?

AMAIA: Oh, yeah. Some things just can't be talked about.

MATÍAS: Like what?

AMAIA: Like your mom. Okay—I know we're lucky to have her. Even with Erick in preschool, it's great that she can pick up the boys in the afternoon and watch them until either you or I get home. But she doesn't always hold to the house rules we've asked her to follow, and then makes up her own. And I can't really talk to her about that, so it has to be you.

MATÍAS: Yeah, and then I'm in the middle—and neither one of you is happy with me. It's a no-win situation.

AMAIA: And then you get all defensive on me . . .

MATÍAS: (*interrupting*) Yeah—you mean like when you're yelling at me because of something my mom did?

THERAPIST: (*pausing the conversation*) Okay—well that probably gives me enough information for now to get a sense of how you can get derailed when talking about these difficult topics, and why either of you might sometimes feel reluctant to initiate such conversations.

Decision to Pursue Further Assessment

Toward the end of the first interview, the therapist shared her initial impressions with the couple. She began with strengths—emphasizing shared values of community service, commitment to their relationship and to their children, strong work ethics, their ability to sustain physical intimacy even in the face of outside stresses, and their willingness to pursue outside help for managing their struggles and restoring the emotional connection that had been so strong earlier in their relationship. She then reflected upon long-standing difficulties the couple had always experienced in resolving disagreements, and gently commented on the possibility that some of these difficulties might be related to communication patterns they'd observed in their families of origin.

The therapist then invited the couple to pursue further assessment, which would be followed by a more explicit decision about whether and how to pursue an initial course of couple therapy. She encouraged a collaborative stance in the assessment process in this manner:

THERAPIST: You've both been so helpful today in sharing with me your concerns about your marriage and by allowing me to observe how your more difficult conversations go when you're on your own. Still, there's so much more I'd like to know about your marriage. I also have some concerns for each of you and how you're holding up with everything that's going on in your lives. You're both such strong persons, but any of us can get a little worn down when the stresses pile up or go on for too long. Does that make sense so far? (*Amaia and Matías both nod.*) So, here's what I'd like to propose. I'd like to send you home with a set of questionnaires for both of you. The longer one will ask all kinds of questions about your relationship—what works well, and what doesn't. That will help me to understand how each of you views the strengths and challenges of your relationship, and where your views are similar or different. I'd want you each to fill out the questionnaire separately, without collaboration. Afterward, you're free to discuss your responses with each other, but you could also choose not to do so for now. I'll ask you to return those questionnaires to me, so I can go over them before we meet and even prepare a summary to share with you both. In our next session, we'll go over your responses together, so we're all on the same page. How does that plan sound?

AMAIA: It sounds fine to me. Sometimes I struggle to find the right words to explain to Matías what I'm feeling—or I start to tell him but the conversation goes sideways.

MATÍAS: The plan sounds good to me, too. Yeah—I don't think I really know how Amaia is feeling about us sometimes. So, it would be good if you could help us with that. I know we've got some issues to resolve. But maybe if we were clear about those—and had similar views on what's working or not—that could help with some kind of game plan for moving forward.

THERAPIST: Great—thanks for that feedback. There's nothing magical or hidden in any of the questionnaires I'll be giving you. What I want to understand is pretty apparent in the questionnaires themselves. (*Amaia and Matías both nod again.*) And like I said, I'm also concerned for each of you, and how you're holding up. So, there's a one-page "screener" questionnaire I'd like you both to complete. Amaia, based on some things you've said today, I'm wondering if perhaps some of those patrols you've been on this past year have stirred up leftover trauma from your prior deployments. Is that a possibility?

AMAIA: Yeah, I'm pretty sure some of that's going on. And then I think that makes it even harder for me to hang in there when Matías and I start arguing—I just need to retreat and find my safe zone.

MATÍAS: (*with genuine empathy*): I'm so sorry . . .

THERAPIST: So, Amaia, how about if we find out just where you are along that scale of PTSD symptoms?

AMAIA: Sounds good.

THERAPIST: And one of the things you've both shared with me today is your sadness over what's been happening at home, and the loneliness and perhaps some pessimism you've been experiencing. All of those can be symptoms of some depression, which we know often develops hand in hand with couple distress. Could we use a screener to see where you're each at in that area? (*Amaia and Matías both nod again.*) Okay, great. So, here's the last item from my side: Matías, I know that Amaia expressed some concern about how much alcohol you're consuming at night, and I noted that you didn't seem to react negatively when she said that. I'm wondering if you have any thoughts on this?

MATÍAS: I don't know. Amaia knows I struggled with alcohol and some pot during college, but not really since. I don't think I consume that much, and it helps me calm down and get to sleep after she and I have had a blow-up.

THERAPIST: Would it be okay to include a screener that helps to clarify your use of alcohol, so the three of us can have a conversation about it in here?

MATÍAS: Sure. I think having an open discussion about it in here might actually reassure Amaia.

Assessment Measures

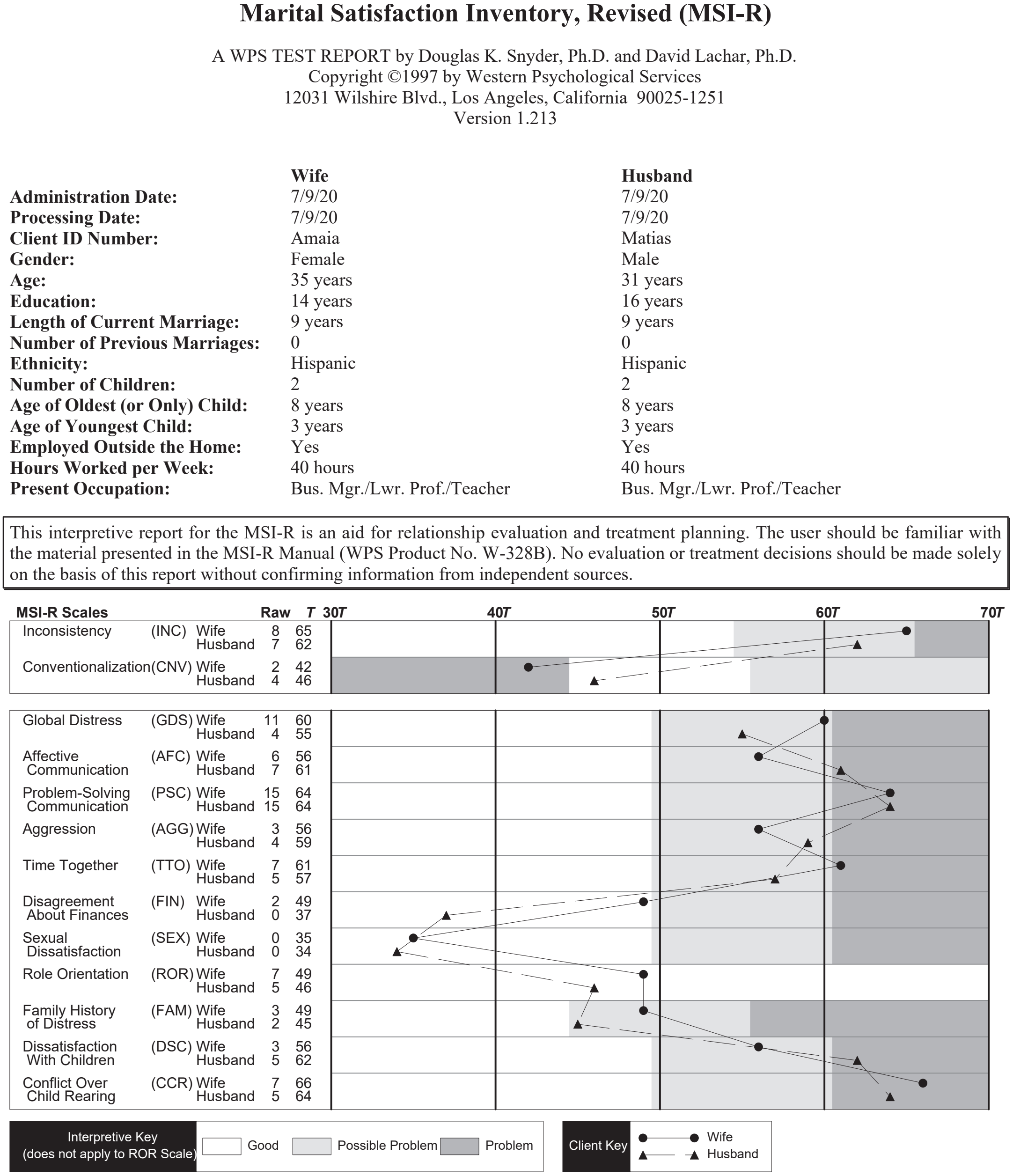
During the following week, Amaia and Matías each completed and returned the MSI-R, along with their responses to three brief screening measures of PTSD (the PC-PTSD), depression (the PHQ-2), and alcohol use (the AUDIT-C). Their scores and profiles on the MSI-R are shown in Figure 2.1.

The couple's scores on the two validity scales (Inconsistency [INC] and Conventionalization [CNV]) were typical of couples entering therapy and reflected an open response style in which relationship concerns were neither minimized nor exaggerated. Both partners reported moderate levels of global relationship distress (GDS), with scores for Amaia and Matías at roughly the 85th and 75th percentiles, respectively, compared to a representative community sample. Overall, the couple's MSI-R profile scales were remarkably parallel, indicating a high degree of concordance in their respective views regarding areas of relationship difficulties and strength.

Both partners obtained their highest scores on scales reflecting difficulties in problem-solving communication (PSC) and conflict over child-rearing (CCR)—placing them at roughly the 95th percentile, and consistent with their primary presenting complaints described in the initial interview. Their scores on a measure of relationship aggression (AGG) were also moderately elevated, consistent with anger dysregulation and verbal tirades but an absence of physical aggression. Also elevated in the clinical range were their scores on measures of emotional intimacy (Affective Communication [AFC]) and enjoyment of time spent together (TTO)—with scores ranging from the 75th to 85th percentile, but with Matías reporting relatively higher concerns about their deficits in emotional connection and Amaia conversely reporting greater concern about their decline in shared leisure activities.

Both partners identified their sexual relationship (SEX) as an area of strength, with scores reflecting significantly higher satisfaction compared to a community sample; neither partner reported significant disagreements regarding their interactions around finances (FIN). Although both partners reported concerns regarding their children (DSC), Matías's reports in this regard were significantly higher than Amaia's and approached the 90th percentile. Both partners reported moderate histories of family dysfunction (FAM), and both espoused gender roles in and outside the home (ROR) that balance traditional and contemporary perspectives.

On the PC-PTSD, Amaia scored a 2 (out of a possible 4), reporting that at times she went out of her way to avoid situations that reminded her of her experiences in Iraq, and at times she felt numb or detached from others. She also scored a 3 (out of a possible 6) on the PHQ-2, indicating that more than half the time she experienced little interest or pleasure in doing things, and often felt "down" or hopeless. Her scores on both the PC-PTSD and PHQ-2 placed her in the "at risk" range in these domains. By comparison, Matías obtained a 0 on the PC-PTSD and a 1 on the PHQ-2—both scores in the nonclinical range. However, Matías scored a 4 (out of a possible 12) on the AUDIT-C, placing him in the "at risk" range for hazardous drinking on this measure. Specifically, he reported consuming alcohol two to three times per week, and typically three to four drinks per occasion. Amaia's score of 1 on the AUDIT-C was within the nonclinical range,



Marital Satisfaction Inventory, Revised (MSI-R)

A WPS TEST REPORT by Douglas K. Snyder, Ph.D. and David Lachar, Ph.D.
Copyright ©1997 by Western Psychological Services
12031 Wilshire Blvd., Los Angeles, California 90025-1251
Version 1.213

	Wife	Husband
Administration Date:	7/9/20	7/9/20
Processing Date:	7/9/20	7/9/20
Client ID Number:	Amaia	Matias
Gender:	Female	Male
Age:	35 years	31 years
Education:	14 years	16 years
Length of Current Marriage:	9 years	9 years
Number of Previous Marriages:	0	0
Ethnicity:	Hispanic	Hispanic
Number of Children:	2	2
Age of Oldest (or Only) Child:	8 years	8 years
Age of Youngest Child:	3 years	3 years
Employed Outside the Home:	Yes	Yes
Hours Worked per Week:	40 hours	40 hours
Present Occupation:	Bus. Mgr./Lwr. Prof./Teacher	Bus. Mgr./Lwr. Prof./Teacher

This interpretive report for the MSI-R is an aid for relationship evaluation and treatment planning. The user should be familiar with the material presented in the MSI-R Manual (WPS Product No. W-328B). No evaluation or treatment decisions should be made solely on the basis of this report without confirming information from independent sources.

MSI-R Scales			Raw	T
Inconsistency	(INC)	Wife	8	65
		Husband	7	62
Conventionalization	(CNV)	Wife	2	42
		Husband	4	46
Global Distress	(GDS)	Wife	11	60
		Husband	4	55
Affective Communication	(AFC)	Wife	6	56
		Husband	7	61
Problem-Solving Communication	(PSC)	Wife	15	64
		Husband	15	64
Aggression	(AGG)	Wife	3	56
		Husband	4	59
Time Together	(TTO)	Wife	7	61
		Husband	5	57
Disagreement About Finances	(FIN)	Wife	2	49
		Husband	0	37
Sexual Dissatisfaction	(SEX)	Wife	0	35
		Husband	0	34
Role Orientation	(ROR)	Wife	7	49
		Husband	5	46
Family History of Distress	(FAM)	Wife	3	49
		Husband	2	45
Dissatisfaction With Children	(DSC)	Wife	3	56
		Husband	5	62
Conflict Over Child Rearing	(CCR)	Wife	7	66
		Husband	5	64

Interpretive Key (does not apply to ROR Scale): ☐ Good ▨ Possible Problem ■ Problem

Client Key: ●——● Wife ▲– –▲ Husband

FIGURE 2.1. Couple profiles for Amaia and Matías on the Marital Satisfaction Inventory—Revised (MSI-R) at initial assessment. Content from the MSI-R copyright © 1997 Western Psychological Services. Reprinted by permission of the publisher, Western Psychological Services (*rights@wpspublish.com*). Not to be reprinted in whole or in part for any additional purpose without the expressed, written permission of the publisher. All rights reserved.

indicating only infrequent and modest use of alcohol.

Feedback Session

In the second session, the therapist shared with the partners a computer-based interpretive report of their MSI-R profiles. Amaia and Matías expressed some relief that, with the exception of conflict around childrearing and more general problem solving, their scores in most areas were in the moderate rather than severe range. They also expressed optimism based on the congruence of their respective profiles, noting that their similar perspectives offered a foundation for where to focus their efforts. As the therapist proceeded to discuss their scores on individual scales, she offered tentative hypotheses regarding how the scores might relate to narratives the partners had offered in the initial interview. She invited Amaia and Matías to join in a collaborative stance to cocreate meaning from test results, noting anywhere the results might not accurately reflect their own experiences, and using these data to formulate potential directions for couple therapy.

Amaia expressed some surprise that Matías had indicated even greater concerns than she had regarding the absence of emotional connection. That provided Matías the opportunity to clarify how distressing it was for him following their arguments when Amaia would withdraw from him, sometimes for days on end. Both of them acknowledged verbal anger dysregulation during their worst arguments, but Amaia then described how those exchanges triggered her feelings of hopelessness and impulses to escape. When their therapist described common demand↔withdraw patterns in distressed couples, Amaia and Matías agreed that their own pattern had progressively worsened over the past year. Their therapist used the couple's responses to the MSI-R to suggest initial targets for change:

THERAPIST: I'm optimistic you can acquire better skills in this regard. We can work at "pause, listen, and recenter" during your conflicts—or using constructive time-outs when regulation strategies in the moment don't work. Matías, we can work at helping you tolerate Amaia's retreat in the short term while she regroups; and Amaia, we could also work at helping you to reengage sooner to tolerate uncomfortable but nonaggressive exchanges between you and Matías.

MATÍAS: We both hate these arguments when they happen, but I think I usually recover sooner and then get frustrated when it takes Amaia longer. That probably makes it even harder for her to reengage.

THERAPIST: That's a good insight, Matías. Last week you both reported similar kinds of communication problems in your respective families. Your moderate scores on this scale of Family History of Distress are consistent with how you each described some good things in your families, but also the patterns of angry escalations—especially by your fathers.

AMAIA: I grew up determined not to be bullied like my mother was. But then I see myself withdrawing and shutting down in the same ways.

THERAPIST: Yes, I can see that. But there's a difference between submissive retreat and constructive time-outs for the purpose of then reengaging more constructively. If we can find ways to turn down the temperature of your escalations, my hunch is that both of you will be able to implement the changes you'll need to help you resolve differences and reach decisions more effectively. What do you think?

AMAIA: I think so. We do better when we can slow things down to hear each other.

Their therapist then suggested that an obvious area in which to learn and practice better communication was around their struggles with managing their older son's anger dysregulation and noncompliance with time-outs. She suggested taking the next few sessions to focus on how to co-parent more effectively, recognizing that things wouldn't get better right away, but anticipating that better communication between the parents would help them plan and implement parenting strategies more consistently. Matías then pointed to their elevated scores on the Time Together scale on the MSI-R and expressed surprise that Amaia had scored as high as she had.

MATÍAS: When you disappear on me for days at a time, I just assume that you don't really even want to be around me.

AMAIA: Yes—after a huge meltdown—it's true that I just need time apart. But mostly I miss the fun we used to have together. I know I sometimes get called in for patrols at night, but even when I don't you seem caught up in your own work.

MATÍAS: The boys take a lot of our time at night, and I admit that tensions around them can leave me feeling exhausted. But you're right, we don't create separate times for us anymore, even on weekends. Maybe in some ways I pursue my own kind of retreat to a safe zone.

THERAPIST: Gosh—those are good points you're both making. There's really good literature on the challenges couples face when they transition into parenthood. And then, with disruptions to your co-parenting early on during deployments, along with perhaps having a more challenging youngster, that created a kind of perfect storm for the breakdown in your own time as a couple. So, while we're working on problem-solving skills and specifically your challenges around parenting, how about we also use time in our initial sessions to restore "connection" times for just the two of you?

AMAIA AND MATÍAS: (*nodding*) Yeah—that would be good.

Their therapist then shifted attention to the partners' scores on the three screening measures they had completed. Specifically, she linked Amaia's scores on the PC-PTSD to her pattern of retreat and emotional detachment following conflict with Matías. That then led to a discussion of how some of Amaia's behavioral and emotional disengagement occurred separately from the couple's conflicts and related, instead, to some of the high-risk incidents she was experiencing at work.

THERAPIST: How often are you able to disentangle for yourself how much of your "retreat to safety" strategy is being triggered by your marriage, and how much by your work?

AMAIA: When I stop to think about it, I probably can figure that out about 80% of the time.

THERAPIST: And how often do you think Matías can disentangle the source—knowing what's from your marriage, and what's from your work? Check it out with him.

AMAIA: (*turning to Matías*) So—can you tell the difference? When I'm withdrawing because of us, or when it's from work?

MATÍAS: Not really—I guess I always figure it's because of us or because of me.

THERAPIST: So, Amaia, one of the things we can work on is helping you to clarify for Matías what's going on with you—because my hunch is that he can engage with you better to offer emotional support when it's from the outside, if he's not worrying that it's because of him. (*Amaia and Matías both nod, offering warmer glances toward each other.*) Matías, there are some responses of yours on one of the screeners that we haven't discussed yet.

MATÍAS: Yeah—I've been waiting for you to bring it up. It's my descriptions of my alcohol use, right?

THERAPIST: That's right. Your responses suggest that you're "at risk" for hazardous drinking or developing patterns that could increase the risk for your marriage.

MATÍAS: I've been thinking about this since our first meeting, and then reading through the questions you gave us. I've already thought of a plan and wanted to present that today while we're together.

THERAPIST: That could be really helpful.

MATÍAS: So, I'm thinking that first off, I move the beers from the fridge to the garage. That way they're not already cold and more of a temptation. And any night that Amaia gets called to work, I pledge not to have any alcohol at all. If I want a beer to calm down after an argument, I only have one—and only if Amaia is also in the house.

AMAIA: That would make a huge difference to me, Matías.

THERAPIST: Matías, I appreciate your initiative in proposing this. How would you both feel about a 30-day trial and then we could discuss the impact for each of you?

MATÍAS: Sounds good. (*Amaia nods affirmingly.*)

Course of Therapy

Amaia and Matías engaged in couple therapy for 4 months. Consistent with a pluralistic approach to sequencing interventions (Snyder, 1999; Snyder & Mitchell, 2008), initial sessions focused on promoting more effective communication strategies and regulating emotions when conflicts emerged. Initial efforts to reregulate during heated exchanges were unsuccessful, and the couple relied on time-outs but were able to reengage more effectively after an hour of separation rather than lapsing into days of protracted retreat. Strategies adopted from narrative therapy helped them explore legacies from their respective families that interfered with their goals of partnering more collaboratively in difficult situations. Amaia came to discern more clearly the distinction between "submission" and "collaborative suspension" of conflict. Matías came to understand that "ideals of excellence" could undermine his wish for closer relationships with his sons when those ideals were enforced in harsh, punitive ways.

Amaia developed better ways of sharing with Matías when conflicts at home or high-risk incidents on patrol triggered her arousal to intolerable levels. In turn, he was more able to approach and support her when the threats were from outside, and to tolerate her retreats when the arousal was from conflicts between them. As they developed more effective coparenting strategies, Matías relaxed his role as "primary disciplinarian" in the home and pursued more positive play time with both their sons. Over several months, both parents reported a significant improvement in the general emotional climate of their home, and a notable reduction in the frequency and intensity of Luis's emotion dysregulations. Halfway through the couple therapy, the couple decided to hire a local college student to provide child care in the afternoons until one of the parents got home, and they transitioned to relying on Matías's mother for child care one evening each week, so they could have separate time as a couple just for themselves.

Throughout the couple therapy, prior to each session, Amaia and Matías completed a five-item screener assessing feelings about themselves, their partner, and their relationship since the prior session, and eliciting information about any notable negative or positive events. Their responses to this presession screener were used to track overall progress, highlight exchanges that had affirmed and strengthened their efforts, and identify any specific issues warranting attention in the current session. As termination approached, both partners once again completed the MSI-R and the screeners of PTSD, depression, and alcohol use they had completed prior to treatment. Their profile scores on the MSI-R showed significant reductions in each area that had indicated distress prior to therapy—with scores reflecting conflict over childrearing and challenges in problem-solving communication decreasing to the low-moderate range of distress (about the 70th percentile), and scores in other domains now in the "good" or "not a problem" range (below the 50th percentile). Neither partner reported any depressive symptoms, and Matías no longer reported indicators of risk for hazardous drinking—with Amaia's concurrence of his gains in this regard. Amaia continued to score in the "at risk" range on the PC-PTSD but clarified that her struggles in this regard were no longer triggered by incidents at home but were tied specifically to enduring challenges at work. The couple's final session provided opportunity to celebrate the changes they had brought to their relationship, with brief discussion of challenges down the road and efforts they could sustain to enhance their resilience.

CONCLUDING COMMENTS

Given the diversity in couples' needs, therapy is most likely to be effective when the therapist engages in comprehensive assessment and selectively draws on intervention strategies across the theoretical spectrum in a manner consistent with an explicit case formulation. Comprehensive assessment of couple distress and related treatment planning require a systematic, dynamic, and culturally sensitive approach. This necessitates a conceptual framework that extends beyond individual considerations and evaluates the broader relational and sociocultural context from which couple distress emerges. We advocate a multifaceted model to guide assessment in primary domains of couple functioning (cognitive, affective, and behavioral) that operate at multiple ecological levels (individual, dyad, nuclear family, extended family, community, and cultural systems). Additionally, couple assessment strategies and specific methods should be tailored to partners' unique constellation of presenting difficulties.

Case conceptualization is a critical clinical skill that lies at the heart of assessment and treatment planning. It is where all the pieces get put together and the linkages are made. The conceptual model presented here for comprehensive assessment across domains and system levels provides a means for linking assessment findings to specific interventions.

SUGGESTIONS FOR FURTHER STUDY

Snyder, D. K. (1997). *Manual for the Marital Satisfaction Inventory—Revised*. Los Angeles: Western Psychological Services.

Snyder, D. K., Cepeda-Benito, A., Abbott, B. V., Gleaves, D. H., Negy, C., Hahlweg, K., & Laurenceau, J. P. (2004). Cross-cultural applications of the Marital Satisfaction Inventory—Revised (MSI-R). In M. E. Maruish (Ed.), *Use of psychological testing for treatment planning and outcomes assessment* (3rd ed., pp. 603–623). Mahwah, NJ: Erlbaum.

Snyder, D. K., Heyman, R. E., Haynes, S. N., & Balderrama-Durbin, C. (2018). Couple distress.

In J. Hunsley & E. Mash (Eds.), *A guide to assessments that work* (2nd ed., pp. 489–514). New York: Oxford University Press.

REFERENCES

Achenbach, T. M. (2009). *The Achenbach System of Empirically Based Assessment (ASEBA): Development, findings, theory, and applications*. Burlington: University of Vermont Research Center for Children, Youth, and Families.

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C). *Archives of Internal Medicine, 158,* 1789–1795.

Cigrang, J. A., Balderrama-Durbin, C., Snyder, D. K., Parsons, A., Lorko, K., Gupta, A., . . . Yahle, C. (2021). Predicting marital health from adverse childhood experiences among United States Air Force active duty personnel. *Couple and Family Psychology: Research and Practice*. [Epub ahead of print]

Cigrang, J., Talcott, G. W., Tatum, J., Baker, M., Cassidy, D., Sonnek, S., . . . Slep, A. (2014). Impact of combat deployment on psychological and relationship health: A longitudinal study. *Journal of Traumatic Stress, 27,* 58–65.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13,* 595–605.

Doss, B. D., & Christensen, A. (2006). Acceptance in romantic relationships: The Frequency and Acceptability of Partner Behavior Inventory. *Psychological Assessment, 18,* 289–302.

Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2015). Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. *Harvard Review of Psychiatry, 22,* 149–161.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9,* 374–385.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21,* 572–583.

Gordon, K. C., Amer, Z., Lenger, K. A., Brem, M. J., Baucom, D. H., & Snyder, D. K. (2019). Forgiveness and the dark side of intimate relationships: Infidelity, intimate partner violence, and divorce. In E. L. Worthington & N. G. Wade (Eds.), *Handbook of forgiveness* (2nd ed., pp. 153–163). New York: Routledge.

Halford, W. K., Hayes, S., Christensen, A. Lambert, M., Baucom, D. H., & Atkins, D. C. (2012). Toward making progress feedback an effective common factor in couple therapy. *Behavior Therapy, 43,* 49–60.

Hausberg, M. C., Schulz, H., Piegler, T., Happach, C. G., Klöpper, M., Brütt, A. L., . . . Andreas, S. (2012). Is a self-rated instrument appropriate to assess mentalization in patients with mental disorders?: Development and first validation of the Mentalization Questionnaire (MZQ). *Psychotherapy Research, 22,* 699–709.

Haynes, S. N., Floyd, F. J., Lemsky, C., Rogers, E., Winemiller, D., Heilman, N., . . . Cardone, L. (1992). The Marital Satisfaction Questionnaire for Older Persons. *Psychological Assessment, 4,* 473–482.

Haynes, S. N., Kaholokula, J. K., & Tanaka-Matsumi, J. (2018). Psychometric foundations of psychological assessment with diverse cultures: What are the concepts, methods, and evidence? In C. Frisby & W. O'Donohue (Eds.), *Cultural competence in applied psychology: Theory, science, practice, and evaluation* (pp. 441–472). New York: Springer.

Heavy, C. L., Larson, B. M., Zumtobel, D. C., & Christensen, A. (1996). The Communication Patterns Questionnaire: The reliability and validity of a constructive communication subscale. *Journal of Marriage and the Family, 58,* 796–800.

Heyman, R. E. (2001). Observation of couple conflicts: Clinical assessment applications, stubborn truths, and shaky foundations. *Psychological Assessment, 13,* 5–35.

Johnson, S. M., & Talitman, E. (2007). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy, 23,* 135–152.

Kerig, P. K., & Baucom, D. H. (Eds.). (2004). *Couple observational coding systems*. Mahwah, NJ: Erlbaum.

Linhof, A. Y., & Allan, R. (2019). A narrative expansion of emotionally focused therapy with intercultural couples. *Family Journal, 27,* 44–49.

Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of Psychosomatic Research, 58,* 163–171.

McGoldrick, M., Gerson, R., & Petry, S. (2008). *Genograms: Assessment and intervention* (3rd ed.). New York: Norton.

Means-Christensen, A. J., Snyder, D. K., & Negy, C. (2003). Assessing nontraditional couples: Validity of the Marital Satisfaction Inventory—Revised (MSI-R) with gay, lesbian, and cohabiting heterosexual couples. *Journal of Marital and Family Therapy, 29,* 69–83.

Murphy, C. M., & Hoover, S. A. (1999). Measuring emotional abuse in dating relationships as a multifactorial construct. *Violence and Victims, 14,* 39–53.

Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., . . . Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society, 53,* 695–699.

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001).

The Suicidal Behaviors Questionnaire—Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment, 8,* 443–454.

Pinsof, W., Zinbarg, R. E., He, Y., Goldsmith, J., Latta, T., & Lebow, J. L. (2015). *Does the STIC measurement and feedback system improve multisystemic outcomes in individual, couple and family therapy?: A randomized clinical trial.* Unpublished manuscript, The Family Institute at Northwestern University, Evanston, IL.

Pinsof, W. M., Zinbarg, R. E., Shimokawa, K., Latta, T. A., Goldsmith, J. Z., Knobloch-Fedders, L. M., . . . Lebow, J. L. (2015). Confirming, validating, and norming the factor structure of Systemic Therapy Inventory of Change initial and intersession. *Family Process, 54,* 464–484.

Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., . . . Sheikh, J. I. (2003). The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry, 9,* 9–14.

Rolffs, J. L., Rogge, R. D., & Wilson, K. G. (2018). Disentangling components of flexibility via the hexaflex model: Development and validation of the Multidimensional Psychological Flexibility Inventory (MPFI). *Assessment, 25,* 458–482.

Snyder, D. K. (1997). *Manual for the Marital Satisfaction Inventory—Revised.* Los Angeles: Western Psychological Services.

Snyder, D. K. (1999). Pragmatic couple therapy: An informed pluralistic approach. In D. M. Lawson & F. F. Prevatt (Eds.), *Casebook in family therapy* (pp. 81–110). Pacific Grove, CA: Brooks/Cole.

Snyder, D. K., Cavell, T. A., Heffer, R. W., & Mangrum, L. F. (1995). Marital and family assessment: A multifaceted, multilevel approach. In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 163–182). Washington, DC: American Psychological Association.

Snyder, D. K., Cepeda-Benito, A., Abbott, B. V., Gleaves, D. H., Negy, C., Hahlweg, K., & Laurenceau, J. P. (2004). Cross-cultural applications of the Marital Satisfaction Inventory—Revised (MSI-R). In M. E. Maruish (Ed.), *Use of psychological testing for treatment planning and outcomes assessment* (3rd ed., pp. 603–623). Mahwah, NJ: Erlbaum.

Snyder, D. K., Heyman, R. E., Haynes, S. N., & Balderrama-Durbin, C. (2018). Couple distress. In J. Hunsley & E. Mash (Eds.), *A guide to assessments that work* (2nd ed., pp. 489–514). New York: Oxford University Press.

Snyder, D. K., & Mitchell, A. E. (2008). Affective reconstructive couple therapy: A pluralistic, developmental approach. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 353–382). New York: Guilford Press.

Snyder, D. K., Simpson, J. A., & Hughes, J. N. (Eds.). (2006). *Emotion regulation in couples and families: Pathways to dysfunction and health.* Washington, DC: American Psychological Association.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38,* 15–28.

Straus, M., & Douglas, E. M. (2004). A short form of the Revised Conflict Tactics Scales, and typologies for severity and mutuality. *Violence and Victims, 19,* 507–520.

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The Experiences in Close Relationship Scale (ECR)—Short Form: Reliability, validity, and factor structure. *Journal of Personality Assessment, 88,* 187–204.

Whisman, M. A. (2007). Marital distress and DSM-IV psychiatric disorders in a population-based national survey. *Journal of Abnormal Psychology, 116,* 638–643.

Whisman, M. A., & Snyder, D. K. (1997). Evaluating and improving the efficacy of conjoint couple therapy. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 679–693). New York: Wiley.

Whisman, M. A., Snyder, D. K., & Beach, S. R. H. (2009). Screening for marital and relationship discord. *Journal of Family Psychology, 23,* 247–254.

PART II

MODELS OF COUPLE THERAPY

BEHAVIORAL APPROACHES

CHAPTER 3

Cognitive-Behavioral Couple Therapy

**Donald H. Baucom, Norman B. Epstein, Melanie S. Fischer,
Jennifer S. Kirby, and Jaslean J. LaTaillade**

BACKGROUND

Cognitive-behavioral couple therapy (CBCT) has been developed, adapted, and expanded over recent decades as a highly efficacious intervention to assist couples in a variety of contexts. The most frequent application of CBCT has been to assist couples with relationship distress. In addition, certain types of relationship difficulties require an expansion or adaptation of the basic CBCT model. For example, helping couples who (1) engage in intimate partner aggression (see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich), (2) experience relationship traumas such as infidelity (see also Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder), and (3) experience individual difficulties in one partner that may be either psychological or medical in nature all require the adaptation of CBCT principles (see also Chapter 24 on posttraumatic stress disorder by Monson & Fredman and Chapter 26 on depression and anxiety by Whisman, Beach, & Davila, both in this volume). We note in this chapter these applications of CBCT principles, with a primary emphasis on using CBCT to treat relationship distress, noting selected specialized applications briefly. The theoretical principles underlying CBCT, the empirical bases, and the interventions involved in applying CBCT are detailed in two major volumes (Baucom, Fischer, Corrie, Worrell, & Boeding, 2020; Epstein & Baucom, 2002) and serve as the foundations for the discussions that follow.

In order to understand the current practice of CBCT, it is helpful to recognize the confluence of three major influences in its historical development: (1) behavioral couple therapy (BCT), (2) individual cognitive therapy (CT), and (3) an ecological perspective for understanding relationship functioning. CBCT emerged in the early 1980s and is a dynamic, ever-changing perspective that continues to evolve as new research findings accumulate and interventions are created to address the treatment needs of a wider array of couples.

Roots of CBCT in BCT

BCT emerged in the late 1960s as a branch of behavior therapies that were based on applications of basic learning principles to clinical problems of individuals. Stuart (1969) published the first application of behavioral principles to couple problems. Stuart hypothesized that successful marriages could be distinguished by the frequency and range of positive acts exchanged reciprocally by the partners, particularly in relation to the frequency of negative acts. Similarly, Weiss, Hops, and Patterson (1973) extended the use of operant principles from parent–child relationships to the treatment of couple discord.

The integration of social exchange and learning principles, and the elaboration of clinical intervention procedures, occurred with the first detailed treatment manuals around 1980 (Jacobson & Margolin, 1979; Stuart, 1980). A traditional behavioral model posits that the behaviors of both members of a couple are shaped, strengthened, weakened, and can be modified in therapy by consequences provided by environmental events, particularly those involving the other partner. The BCT model also proposes that couples are distressed in part because they have not developed or maintained the skills necessary to produce interactions that result in feelings of closeness in their relationships. The early BCT manuals placed heavy emphasis on teaching effective relationship skills, largely communication skills.

Influences of CT on CBCT

The second major influence on the development of CBCT was the rise of cognitive models of individual psychopathology (e.g., Beck, Rish, Shaw, & Emery, 1979), emphasizing how an individual's emotions and behaviors are mediated by idiosyncratic interpretations that may be biased by cognitive distortions. CBCT evolved by incorporating a major focus on cognitive factors relevant to the couple's relationship as influencing the onset and treatment of couple distress, while maintaining the core of BCT. In CBCT, cognitive, behavioral, and emotional factors are all given attention. A major premise of this approach is that dysfunctional emotional and behavioral responses to relationship events are influenced by information-processing errors, whereby cognitive appraisals of the events might be distorted (e.g., "You went out for drinks after work because you like your friends more than me"). Similarly, relationship distress might result from extreme standards of what a relationship should be (e.g., "If we really had a healthy relationship, we would never fight"). Thus, in addition to partners' behaviors, their internal, subjective cognitive and emotional responses are central to relationship well-being.

Ecological Influences on CBCT

Bronfenbrenner (1989) proposed an ecological perspective on human behavior, emphasizing that individuals live within broader units and systems that have a mutually reciprocal influence on each other. In the current context, these units include (1) each partner as an individual, (2) the couple as a unit, and (3) the broader social and physical environment (e.g., family, neighborhood, workplace, societal conditions). Within this framework, all three domains must be taken into account, balanced, and adapted on an ongoing basis. Integrating this ecological perspective within CBCT means that cognitive, emotional, and behavioral factors are considered across the three domains.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

CBCT defines a healthy relationship within a contextual perspective, as one (1) that contributes to the growth and well-being of both partners, (2) in which the partners function well together as a unit, and (3) in which the couple relates to their physical and social environment in an adaptive fashion over time. Across units of the contextual model, an understanding of central behaviors, cognitions, and emotions is integral in conceptualizing relationship functioning. Given that there are two individuals, each with their own behaviors, cognitions, and emotions, and given that these processes are interdependent between partners, there is a reciprocal, bidirectional, ongoing set of actions and reactions between the partners. Relationship functioning hinges on these processes, as well as the couple's ability to adapt to life changes over time. CBCT does not assume one primary source or single mechanism of relationship dysfunction; instead, distress results from a combination of the previously mentioned factors most relevant for a given couple.

As noted earlier, a healthy relationship contributes to the well-being of both individuals. A common source of relationship distress is one or both partners' experience that their relationship is not meeting important needs and goals, or that the other partner does not respect who that person is. In a healthy relationship, the partners are able to negotiate their needs or motives, personality factors, and other sources of individual difference, including cultural factors that can be a source of difficulty for couples. Fundamental needs or motives often relevant in couple relationships include communal needs (to be part of a unit; to be intimate; to be altruistic to others; to be nurtured) and individually focused needs (for autonomy, control, and achievement). Differences in partners' needs, as well as other differences (e.g., in personality traits), can lead to relationship distress if the couple has not found a way to navigate them. For example, partners who differ in their desire for intimacy or their preferences for control, organization, and planning may respond to resulting frustration by becoming emotionally upset, behaving negatively toward each other, and distorting interpretations of each other's behavior as they attempt to get their needs met. Distress resulting from unmet fundamental needs is described in CBCT as "primary distress." In contrast, partners' use of maladaptive strategies to influence each other in response to primary distress (e.g., by withdrawing or verbally attacking each other when needs are unmet) can create "secondary distress."

Much attention in behaviorally oriented research on couples focuses on couple-level processes such as communication behaviors and interaction patterns. In addition to these important micro-level processes, well-functioning relationships are able to navigate a number of macro-level processes. Satisfied couples tend to have a sense of being a unit (Sullivan & Baucom, 2005) and have translated this joint identity into concrete behaviors, routines, and ways of living that maintain that identity. To achieve this goal, couples need (1) mutually satisfactory boundaries around their relationship, clarifying which aspects of their lives and behaviors are solely theirs and not shared with outsiders; (2) an investment of effort from both partners so that the relationship functions well; and (3) an ability to balance stability and change to be responsive to the evolving context within which they live. Over the course of their relationship, many couples go through a variety of normative transitions (e.g., moving in together, becoming parents, entering retirement) as well as unexpected changes (e.g., health crises) that require them to adapt. Transitions are vulnerable time points for difficulties to emerge, particularly if the couple is unaware of the need to adapt or "slides" into a new stage without discussing whether their expectations, needs, and values are compatible (Stanley, Rhoades, & Markman, 2006). Couples also need to develop the more detailed aspects of how they operate as a unit, as to how they relate and accomplish tasks, especially during life transitions. Couples need to decide how to make decisions, how power is allocated in various domains, and how they communicate to stay connected.

Finally, the couple's broader social and physical environment can provide important resources, as well as exerting demands that tax the couple's coping capabilities. In turn, the couple can act as an agent of influence on their environment. For example, being embedded in a social community such as extended family or a religious community can provide connectedness and support. At the same time, a pileup of ongoing external stressors (e.g., work stress or discrimination stress associated with one's identity) or the occurrence of unexpected stressors (e.g., a major illness of a close family member) can overwhelm a couple and result in distress and crisis in the couple relationship.

Behaviors, Cognitions, and Emotions across Domains

Across the three domains noted earlier, each partner's behaviors, cognitions, and emotions, as well as the resulting interpersonal interaction patterns are central to the couple's ability to function well and respond to challenges and changes. Below is a brief overview of these elements emphasized within the CBCT model, with a focus on aspects that appear most central in distressed relationships and serve as points for intervention.

A central factor in individuals' experience of the relationship is how they think about it, process what happens on a daily basis, and anticipate the future. Baucom, Epstein, Sayers, and Sher (1989) differentiated among several categories of cognitions that can play a role in relational distress. These include cognitive processing factors such as selective attention and relationship schematic processing, as well as the content of momentary inferences about specific events, including attributions and expectancies, and broader and stable relationship beliefs or schemas, including assumptions and standards. Differences between partners' beliefs (e.g., different standards for how partners should express caring) can be a source of distress and conflict. Cognitions can be both predictive of relationship distress and a symptom of it. For example, selectively attending to negative partner behaviors can contribute to relationship distress, and partners who already are unhappy with each other are more likely to make negative attributions for each other's behaviors (see Epstein & Baucom, 2002, for a review).

Whereas emotions can occur in response to behaviors and cognitions, emotional processes are also important to consider for their own influence on relationship functioning. For example, a relationship might be characterized by the frequency with which positive versus negative emotions occur. A distressed couple might primarily experience negative emotions and few positive ones, or they may experience a paucity of emotion toward each other. Likewise, an individual's trait-level propensity to experience negative emotions (neuroticism/negative affectivity) as well as problems with individual emotion regulation can contribute to relationship difficulties. Even when the partners do not struggle with emotions on their own, individual or cultural differences in how each person communicates emotions can create difficulties for couples as well (e.g., partners from different family backgrounds viewing each other as "too dramatic" vs. "cold and uncaring").

Differences in behaviors and interaction processes between satisfied and distressed couples have been subject to decades of research. Behaviors central to relationship functioning include adaptive and maladaptive communication behaviors (e.g., attacking/criticizing vs. constructive discussion), the balance between positive and negative behaviors, and interaction patterns such as negative reciprocity or demand–withdraw patterns (Eldridge & Christensen, 2002). Behavioral aspects of relationships can contribute to distress if they interfere with life "running smoothly" (e.g., the couple is unable to make joint decisions) or if they undermine one or both partners' sense of being respected, valued, and cared for (e.g., lack of caring or intimacy-building behaviors, being criticized by one's partner).

Cultural and Identity-Related Factors

Similar to many domains of couple research, most studies addressing aspects of relationships from a cognitive-behavioral perspective have involved samples that comprise predominantly White, middle-class, cisgender participants in mixed-gender relationships. While studies with more diverse samples or with a focus on traditionally underrepresented couples continue to increase, the flexibility and contextual focus of the CBCT model provide a useful framework for cultural considerations. The cultural identity of each partner, broadly defined (e.g., in terms of gender identity, race/ethnicity, national origin, religion, sexual orientation, socioeconomic status, age, ability; Iwamasa & Hays, 2019), as well as differences between partners are likely to play a role at each level of the CBCT model. For example, standards about relationships often are culturally bound, such as the emphasis given to the nuclear versus extended family or expected gender roles. Similarly, communication can vary greatly, for example, in terms of the degree to which open expression of emotions is valued versus seen as inappropriate (e.g., Epstein, Curtis, Edwards, Young, & Zheng, 2014). Likewise, diversity-related considerations are relevant at the individual, couple, and environmental levels. For example, because many people maintain close friendships with others of the same gender, same-gender couples describe greater ambiguity during relationship formation ("Is this a date?") and in terms of boundaries with friends while in a relationship (Scott, Whitton, & Buzzella, 2019). Furthermore, experiences of oppression (see also Chapter 12 on socioculturally attuned couple therapy, in this volume, by Knudson-Martin & Kim; e.g., based on racial/ethnic identity, sexual and gender minority status, class) are key features of the couple's environment and sources of chronic stress, with negative implications for relationship functioning (e.g., LaTaillade, 2006; Scott et al., 2019). Thus, challenges that couples with various backgrounds encounter, as well as the specific strengths and protective factors that can help them, are an important part of understanding relationship functioning.

THE PRACTICE OF CBCT

The Structure of the Therapy Process

CBCT often is implemented as a brief therapy approach, ranging from several to over 20 weekly sessions, depending on the severity of problems in individual and/or couple functioning. It consists of two major phases: assessment and treatment. The assessment (described in more detail below) typically is conducted over two to four sessions and results in a case conceptualization, goal setting, and treatment plan that are discussed with the couple. During the main phase of treatment, sessions typically are conducted weekly. Toward the end of treatment, it is common to phase out therapy gradually, as a couple achieves their initial goals for therapy. CBCT does not assume that all of a couple's issues will be resolved in treatment, but rather that the couple will be better equipped to address remaining and new issues on their own. Periodic "booster" sessions also may be scheduled.

Use of Homework Assignments in CBCT

CBCT therapists routinely collaborate with couples in designing activities to be completed between sessions. Use of "homework" is based on the learning principle that to replace existing (often ingrained) dysfunctional interaction patterns with new adaptive ones, a couple needs to rehearse the new patterns repeatedly, particularly under "real-life" conditions that are more varied and more challenging than those in session. For example, a couple might practice communication skills at home that they practiced under the therapist's guidance during sessions. It is important that the therapist explore partners' possible negative cognitions about homework (e.g., "These practice conversations won't help") to increase the likelihood of compliance and success.

Inclusion of Other Individuals in Couple Sessions

Most often, CBCT includes only the two members of a couple, although significant others who influence the couple's functioning might be included occasionally (with more extensive involvement shifting the modality to family therapy). The rationale for including another person is to give the therapist an opportunity to observe and discuss the impact that this person has on the couple's interactions, as well as to allow the couple to practice interacting differently with the individual. For example, after devoting sessions to improving the partners' collaborative parenting behavior, the couple could bring their child to a session to practice effective co-parenting with the therapist present. As described earlier, CBCT considers the couple's social environment (e.g., children, extended family) as an important aspect of relationship functioning. Whether or not others are present in sessions, they often are discussed during assessment and intervention conducted with only the couple.

Sessions with Individual Partners

Because the couple is considered "the client" in CBCT, in most cases, individual sessions are conducted only during the initial assessment, as described below. However, exceptions can be made if the therapist believes there is an important rationale for it, both members of the couple agree, and the therapist and couple believe that this will be conducive to, rather than interfere with, the overall treatment and therapeutic alliance. For example, if one member of the couple has had significant difficulty regulating emotional responses in the partner's presence and attempts to intervene have been unsuccessful, the therapist might meet with the individual to coach them in anger management strategies to prepare for subsequent joint sessions. Often, contact will be limited to one or a small number of individual sessions; if more extensive intervention is needed, then a referral to another therapist for individual treatment can help to maintain therapeutic boundaries. Prior to individual sessions, expectations and guidelines regarding confidentiality should be agreed upon with the couple (see "Assessment" for guidelines).

Medication, Individual Therapy, and CBCT

Given the common co-occurrence of individual psychopathology and relationship problems, often one or both partners enter CBCT on medication and/or in individual therapy. CBCT therapists view treatment for individual difficulties as an appropriate collateral treatment to couple therapy. However, it is crucial that the individual treatment not result in that partner being deemed responsible for all problems in the relationship. Furthermore, it is advisable for the couple therapist to obtain consent to contact the other mental health provider(s) and exchange information so that the two therapies proceed in a compatible manner.

The Role of the Therapist

The therapist assumes multiple roles in CBCT that vary within a given session and across the course of treatment. These roles are influenced by (1) an ongoing conceptualization of a couple's functioning along with *specific intervention strategies* and (2) the development of an *optimal therapeutic environment* to assist the couple in achieving their goals. As noted below, at certain times, the therapist assists in a more instrumental manner; importantly, this is carried out with careful attention to the therapeutic atmosphere and therapeutic relationship, with the therapist employing a wide range of therapeutic responses to achieve desired goals.

The Therapist as Educator, Consultant, and Skills Trainer

In many instances, couples struggle to understand why problematic patterns continue, primarily reporting that it "just isn't working, and we don't seem to be able to change it," or blaming their partner. Thus, at times, the therapist serves in the role of educator or consultant in providing psychoeducation to help the couple gain a perspective on factors contributing to and maintaining their distress. For example, during initial feedback, a CBCT therapist might help a couple understand how their differing desires for intimacy, difficulties communicating emotions, and discrimination experiences in the environment are contributing to their relationship distress. However, because most couples have developed self-maintaining, maladaptive patterns, better understanding of their distress is rarely sufficient. Thus, the therapist assists the couple directly in making needed changes. At times, this might involve moving into the role of a skills trainer, for example, to foster effective communication, while also attending to the important content that couples are discussing. In such instances, the session often involves the partners communicating directly with each other, and the therapist assumes the role of coach. On other occasions, new skills are not needed, but the couple would benefit from making changes in ways of interacting day to day, with the therapist serving as a facilitator to help identify and encourage change (e.g., deciding on a date night away from the children). In addition to these specific, initial roles, CBCT therapists also assume a broader therapeutic role with more complex considerations regarding the therapeutic relationship, as outlined below.

The Therapeutic Relationship

In addition to employing specific interventions and assuming different roles, *how* the therapist interacts with the couple during the sessions is crucial to facilitate change. Furthermore, the therapist's style must adapt to the needs of a given couple at a given point in treatment. For example, early in therapy while working with dispirited couples with low energy, the therapist might serve as a motivator or cheerleader for couples who are discouraged, providing reinforcement for adaptive change. On the other hand, the therapist might provide a great deal of structure and lower the emotional "temperature" for couples who rapidly escalate into high levels of emotion.

These multiple roles that a CBCT therapist adopts over the course of treatment are implemented within the context of the therapeutic relationship. This relationship includes factors that are important in psychotherapy in general, often referred to as "common factors" (see also Chapter 13, in this volume, by Davis). Consistent with the empirical findings of the American Psychological Association's second Interdivisional Task Force (APA Divisions 12 and 29), it is crucial that a CBCT therapist be empathic with a couple, demonstrate genuine positive regard, and be respectful and supportive of both partners who often are not working toward common goals. In addition to common factors that transcend theoretical orientations, Kazantzis, Dattilio, and Dobson (2017) point out CBT-specific relationship elements that include the therapist and client working together as a team to explore and examine the client's cognitions, emotions, and behaviors. Applied to CBCT, this approach often involves the therapist noting principles that facilitate healthy relationships and collaboratively deciding with the couple if and how they might take these principles into account in their own relationship, never providing "rules" or dictating changes. The therapist works with the couple to gather information from everyday life and the sessions to guide the course of treatment (empiricism). Finally, the CBCT therapist often uses Socratic dialogue with the couple to help them explore different ways of thinking about their relationship and interacting, rather than directly challenging cognitions such as standards about characteristics a relationship should have.

Finally, there are therapeutic relationship factors focal to CBCT that take the dyadic context and nature of relationship distress into account. A full discussion of these CBCT-specific factors is beyond the scope of this chapter and is detailed elsewhere (Baucom et al., 2020). One central aspect to note, however, is the degree of structure and direction provided by CBCT therapists, based on the observation that many couples quickly replay their maladaptive interaction patterns and need assistance in changing them. A general guideline is to provide only the degree of structure and direction needed to help a couple be successful, which will vary by couple and stage of treatment. For example, as noted earlier, the therapist might provide a great deal of structure in session with a highly volatile couple. Similarly, for a couple who has difficulty following through on their plans outside of session, the therapist might help the couple structure their homework assignments in a more detailed manner. Because it is important for a couple to develop a sense of efficacy and take responsibility for their relationship, over the course of therapy the therapist typically becomes less active and directive.

In summary, therapists incorporate a variety of cognitive, emotional, and behavioral interventions within the context of a caring, empathic, collaborative relationship in which they share openly what they observe and provide suggestions and skills as needed to help the couple make mutually agreed-upon changes. The degree of structure and direction, and use of various therapeutic interventions and adaptations over the course of therapy, are all based on an ongoing functional analysis of both the couple's relationship and the therapeutic relationship.

Assessment

In CBCT, the goals of the assessment are to (1) determine whether CBCT is appropriate for the couple and (2) develop a case conceptualization and tailored treatment plan by clarifying the cognitive, behavioral, and emotion-related factors at the individual, couple, and environmental levels that contribute to their presenting concerns, along with the couple's strengths. The couple's cultural background and identities are considered as aspects of each component of the contextual model. Assessment also continues throughout treatment and serves not only to monitor progress in targeted treatment areas but also to test hypotheses and refine treatment conceptualizations generated as a result of the initial assessment.

Methods and Structure of the Assessment

Unless a couple enters therapy in acute crisis or the setting requires a shorter process, the first two to four sessions are devoted to assessment. Ideally, assessment sessions are 1½ to 2 hours long or are held more than once a week to avoid prolonging the assessment process across many weeks. The initial assessment involves multiple strategies for information gathering, including (1) joint interviews with the couple, (2) self-report questionnaires, (3) direct observations of couple communication, and (4) individual interviews with each partner, as described below. During many portions of the assessment, the therapist speaks to each partner, one at a time, while the other partner listens (while making it clear that there is no expectation for partners to see the situation the same way), rather than partners speaking to each other. This helps the therapist provide appropriate structure and avoids conflict from escalating quickly if partners were to discuss problematic issues with each other. The assessment begins with a joint session during which the therapist orients the couple to the assessment process, then progresses through the following stages across sessions with both partners present, except for the individual interviews:

- Brief overview of presenting concerns
- Assessment of the relationship history
- Detailed assessment of current relationship functioning (including questionnaires)
- Observation of couple communication
- Individual interviews regarding each partners' individual history and functioning

Based on these steps, the case conceptualization is developed and jointly discussed with the couple during a feedback session, as discussed further below in "Goal Setting." In most instances, the assessment begins with an overview of current concerns and the assessment of the relationship history, with the order of subsequent components being more flexible.

BRIEF OVERVIEW OF PRESENTING CONCERNS

After providing an explanation of the aims and structure of the assessment and treatment phases, the therapist obtains an overview of each partner's main concerns. This is meant to be an initial brief overview, with the therapist speaking to each partner for approximately 5–10 minutes while the other partner listens, noting that they likely have different perspectives. This discussion provides the therapist with an initial overview of the couple's major difficulties, including themes that can then be traced from a developmental perspective during the subsequent relationship history.

ASSESSMENT OF RELATIONSHIP HISTORY

The relationship history places the presenting concerns in context and helps the therapist understand how the current difficulties have evolved over time. This interview focuses on significant events and periods of transition and how the couple managed these events (e.g., moving in together, relocations, transition to parenthood, or major family crises and losses), as well as individual and couple strengths and resources in their environment. Tracing the early beginnings of later difficulties also helps to begin understanding sources of primary distress (e.g., personality differences that have not been addressed effectively) versus secondary distress (ineffective arguments that initially resulted from unmet needs). The relationship history also allows the therapist to assess the couple's behaviors and interaction patterns, their cognitions about what has happened (e.g., blaming each other for issues in the relationship), and their emotional responses, as well as the overall emotional tone of the relationship across time. Thus, the framework of considering the two individuals, the couple as a unit, and their environment while attending to behaviors, cognitions, and emotions guides the interview. If psychopathology is a central aspect of the couple's concerns, the history of the disorder can be assessed here as well, with a focus on how the relationship has affected the disorder and vice versa. Additionally, the discussion of initial attractions and couple dynamics during early stages of the relationship provides an opportunity to reexperience positive emotions and bring couple strengths back into focus, which also can foster a sense of hope.

In conducting the relationship history, it is helpful to structure the interview according to major relationship phases, adapting this structure and how much attention is given to each phase depending on the length of the relationship and complexity of concerns. Common phases to inquire about include (1) initial meeting, early attractions and interactions while dating; (2) a phase of the relationship when the partners became "more serious"; (3) the relationship since some form of formal (e.g., marriage) or informal long-term commitment; and (4) other relevant, later couple developmental stages such as retirement. If the couple has children, this often signifies another notable transition point, as do deaths of partners' parents.

As noted earlier, in addition to the specific content relevant to each set of life circumstances, therapists commonly inquire how the couple functioned during each stage in terms of behaviors (e.g., communication and major interaction patterns such as approach or withdrawal in response to conflict), cognitions (e.g., attributions regarding each other's behavior), and emotions (e.g., each person's tendency to experience or express emotions intensely vs. holding back). Because major life transitions are a vulnerable time for difficulties to arise, therapists assess how the couple approached transitions and adapted to new circumstances (e.g., planning ahead and reaching careful decisions together vs. "stumbling" into new life phases).

ASSESSMENT OF CURRENT RELATIONSHIP FUNCTIONING

During a conjoint interview, the therapist seeks a more in-depth understanding of the couple's current relationship in terms of individual, couple, or environmental factors that influence the couple's ability to manage their current circumstances. The therapist focuses this interview according to which domains need additional attention after completing the previously discussed phases. If not already discussed, therapists inquire about how disagreements and conflicts are currently dealt with, as well as other topic areas that couples might be less likely to raise themselves. These include concerns about their sexual relationship, use of alcohol and other substances, physical aggression or violence in the relationship, as well as areas of relative strength in the relationship.

The use of questionnaires can support the assessment of current functioning in an efficient manner; it is helpful if the couple can bring completed questionnaires prior to this interview so that the therapist can ask targeted questions based on specific responses. While a multitude of questionnaires might be relevant for various couples, in most cases, it is helpful to assess the domains of (1) overall relationship satisfaction (e.g., Dyadic Adjustment Scale [Spanier, 1976]; Marital Satisfaction Inventory—Revised [Snyder, 1997]), (2) desired change in specific domains (e.g., Areas of Change Questionnaire [Weiss et al., 1973]), (3) aggressive behaviors (e.g., the revised Conflict Tactics Scales [CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996]), and (4) individual functioning/psychopathology (various available measures and screening instruments).

OBSERVATION OF COUPLE COMMUNICATION

The therapist samples partners' communication by asking the couple to engage in one or more conversations (7–10 minutes each), while the therapist observes their process (or leaves the room if videorecording is available). Typical conversation prompts include (1) discussing an area of moderate concern in their relationship, so the therapist can observe how they make decisions; (2) sharing thoughts and feelings about themselves or some aspect of the relationship, so the therapist can assess their expressive and listening skills; or (3) engaging in a conversation requiring partners to provide each other with instrumental or expressive support.

INDIVIDUAL INTERVIEWS

Brief individual interviews (20–30 minutes) without the partner present allow the therapist to learn more about pertinent factors in partners' histories that might influence them in the current relationship. Thus, the goal of these interviews is to learn about each partner as an individual, not to discuss the couple's relationship in the absence of the other partner. Therapists can ask clients to provide a brief overview of their lives from childhood until now in order to identify influential themes or events. Topics include early childhood experiences and family of origin (early relationship models), issues regarding physical and mental health or substance use, trauma, personal characteristics, previous experiences in intimate relationships, and educational and work history. A host of issues is likely to arise in a limited amount of time. Therefore, the therapist asks for brief information about each domain, then focuses the conversation on areas that appear most relevant in terms of their impact on current relationship functioning. The therapist also addresses any concerns about risk to the individual's safety related to stated or suspected partner aggression or related to suicidality.

The individual interviews might include sensitive information that the person is reluctant to share in detail with the partner, such as experiences with previous partners or a history of abuse victimization. When these experiences are not implicated in the couple's current issues and the individual wishes to keep them private, they do not need to be shared in conjoint sessions. However, it will be important to consider the effects of these experiences on current issues and the potential benefits and costs of sharing this information with a partner. Importantly, however, the therapist should clarify prior to the individual interviews that the therapist cannot be put in a position of keeping a secret from the other partner (e.g., regarding an ongoing affair) when the person gives contradictory information in joint sessions. This would put the therapist in an untenable position and undermine any shared agenda for treatment. Should such information be disclosed anyway, the therapist discusses with the disclosing person how this might be shared with the partner in session. If the disclosing person does not agree to proceed in this manner, the therapist explores with that person how sessions can be discontinued. The exception to the therapist "keeping secrets" concerns disclosures of partner aggression during individual sessions when sharing such disclosures with the perpetrator may put the victimized partner at further risk. In this case, the therapist conducts a risk assessment and discusses options to ensure personal safety (see Chapter 17 on partner aggression, in this volume, by Epstein et al.).

Taking into account the various types of information provided by the couple during the assessment process, the therapist proceeds by developing a case conceptualization.

Goal Setting

Case Conceptualization

A case conceptualization involves integrating the information that is obtained during the assessment, with an emphasis on factors central to the development and maintenance of relationship distress. In most instances, this involves identifying three or four major themes most relevant in understanding the couple and developing a treatment plan. Thus, the conceptualization is tailored to each couple in an idiographic manner. Also, consistent with the notion of collaborative empiricism in CBT, the initial conceptualization is open to revision when shared with the couple as discussed below, along with ongoing updates during treatment.

In developing a case conceptualization, the therapist considers the two major frameworks discussed throughout this chapter: (1) the contextual model (i.e., the individual, the couple, and their environment) and (2) a CBT perspective, including both partners' cognitions, emotions, and behaviors. These factors combine in different ways to portray each unique couple. The therapist selects the three or four major themes (e.g., lack of closeness) that appear to be most central to the maintenance of relationship distress, then elaborates on nuances within each theme to refine the description of factors influencing the couple. Typically, this elaboration includes specifics of how broader themes are manifested on a day-to-day basis. The therapist also explores how these major themes are interrelated. For example, both Marion and Dante grew up in families that were warm and caring, with a major emphasis on giving to others. They were attracted to each other because of their shared values and focused a great deal of their energy on altruistic activities, with little time left for their own relationship. They continued these efforts with the birth of their first child, who had special needs. Because they did not want to "complain" about their struggles, they rarely talked about how overwhelmed they felt. They finally sought therapy because they felt distant from each other. The therapist concluded that their altruistic motives were laudatory, but they had lost a balance between attending to others versus their own relationship and, thus, felt distant. In an attempt to stay positive, they avoided voicing their concerns and inadvertently minimized opportunities to support each other, further exacerbating their experience of being distant. Also, Dante's inability to express his feeling distant exacerbated his preexisting vulnerability to depression. There were additional factors that the therapist wove into her understanding of the couple that would influence treatment, but the theme regarding distance served as the core for case conceptualization and treatment planning.

Treatment Planning

The case conceptualization leads directly to an initial treatment plan that the therapist develops tentatively and is revised collaboratively based on discussion with the couple. This treatment plan addresses how various cognitive, behavioral, and emotion-focused interventions described below can be employed to address each of the major identified themes.

Because CBCT is principle-based rather than a manualized intervention, broad principles are used to determine sequencing of interventions in a flexible manner for each specific couple. This typically begins with the assessment and case conceptualization, followed by a feedback session with the couple. Once "treatment proper" begins, there are principles that influence the order of issues that are addressed. First, at times, there are issues that require immediate attention because of their time sensitive or highly detrimental impact on the couple or one partner, such as partner aggression. Next, treatment can turn to more persistent, ongoing issues couples are confronting. Because the great majority of distressed couples experience notable communication difficulties, helping them strengthen their communication is common early in treatment, so that they can effectively discuss the myriad issues before them. Likewise, negative behaviors, whether communication or otherwise, have a particularly detrimental effect on relationship functioning, so helping couples decrease negative behaviors is emphasized from the beginning of treatment. Often, this involves decreasing sources of secondary distress first, such that couples are then able to interact constructively to address (often more vulnerable) issues at the core of their primary distress. Because optimal relationships also involve ongoing positive behaviors between partners, if a couple expresses few positive behaviors toward each other, the therapist helps them increase these types of interactions, often after a high level of negative interaction has decreased.

Whereas the therapist might be adept at conceptualizing the couple's difficulties and how they might improve their relationship, partners might differ in their initial goals in therapy, for example, whether they both are committed to continuing the relationship (see also Chapter 21 on divorce, in this volume, by Lebow). These differences are discussed openly in the feedback session, often with the therapist emphasizing the importance of both partners committing to the therapy process at least on a trial basis, even though they may not feel committed to a given outcome such as staying together.

Feedback Session

Following the assessment, the initial conceptualization and potential treatment plan are discussed during a feedback session. This feedback provides an opportunity for the couple to hear an integrated understanding of their difficulties within the context of what is known about healthy and maladaptive relationships. Throughout this discussion, the therapist maintains a collaborative approach with the couple, offering the therapist's perspective on what the couple has shared, asking for their feedback and how it fits with their experience, and revising the conceptualization as appropriate. As various aspects of the conceptualization are discussed, the therapist describes how therapy might approach each domain, providing the couple an opportunity to help shape the treatment plan.

The previous description is based on the assumption that conjoint therapy is appropriate for the couple. If the therapist concludes that this is not an appropriate or sole course of intervention needed to assist the couple, this is discussed in the feedback session. Likewise, it is not assumed that the couple is committed to treatment until they have received the feedback and have a clearer perspective of how the therapist perceives their relationship and what might be involved in therapy. Consequently, the therapist asks the couple if they would like time at home to discuss whether they want to proceed with therapy or are ready to make a decision at the moment. If both couple and therapist agree to couple therapy, it proceeds, recognizing the importance of making changes in the conceptualization and treatment plan if needed as intervention proceeds.

Process and Technical Aspects of CBCT

Given the interconnections among the components of the CBCT model within and between partners, each domain provides a "portal of entry" to intervene with a couple, recognizing that intervening in one domain (e.g., behavior) will likely have notable impact on the other two domains (i.e., cognitions and emotions). Thus, CBCT incorporates a variety of behavioral, cognitive, and emotional interventions, as described briefly below.

Interventions for Modifying Behavior

In order for couples to be satisfied with their relationship, it is essential that they treat each other well, including few negative, destructive actions and a range of ongoing positive behaviors that affirm each other and contribute to life proceeding smoothly. CBCT therapists employ a wide range of specific behavioral interventions to help couples potentially experience the richness that contributes to optimal relationship functioning. These specific interventions fall into two broad categories: guided behavior change and skills-based interventions. Whereas the interventions can sound straightforward, their application is most effective within the context of a comprehensive case conceptualization in which the interventions are targeted at central relationship goals and within the context of a positive therapeutic relationship.

GUIDED BEHAVIOR CHANGE

Guided behavior change involves helping the couple make changes, often outside of the therapy session, without having to learn any new skills. These behavior changes flow from the case conceptualization and typically result from a discussion between the couple and therapist. Thus, Marion and Dante's decision to have date nights without children present resulted from a discussion with their therapist about the importance of taking time to nurture connection within their relationship. As is often the case, in this instance, the therapist provided the relevant principle of balancing the desire to give to others with attending to their relationship, and the couple decided on the specifics of how they would behave to accomplish that goal. Thus, the therapist rarely attempts to establish the types of rule-governed behavior exchanges that were common in the early days of BCT. Instead, therapist and couple together develop a series of agreements on how the partners want to make changes in their relationship.

These types of guided behavior changes can be implemented at two levels of specificity and for different reasons. First, a couple and therapist may decide that they need to change the overall emotional tone of the relationship broadly because the partners are demonstrating few caring/loving behaviors. Therefore, the couple might decide that each partner will engage in at least one small, caring behavior toward the other each day, hopefully establishing a habit that will be maintained through natural consequences (Weiss et al., 1973). Guided behavior changes also can be used in a more focal manner to address specific themes associated with relationship distress, such as increasing actions associated with intimacy or actions that increase the degree to which individual needs (e.g., autonomy) are met. Whereas agreeing to adaptive behavioral changes might proceed well, actually implementing and maintaining these changes is difficult for many couples. Thus, a great deal of time in session might be spent helping couples clarify and addressing the barriers to such changes (e.g., fear of being vulnerable and getting hurt).

SKILLS-BASED BEHAVIORAL INTERVENTIONS

Skills-based interventions involve the therapist providing the couple with guidelines to assist in the use of particular behavioral skills, using didactic discussions, readings, or videos, according to a particular couple's receptivity to different ways of taking in new information. This is followed by opportunities for the couple to practice behaving in the new ways, often within a session initially, using the guidelines to address important substantive areas of concern to the couple. Communication training typically has involved this format, differentiating between two major types of conversations: (1) couple discussions focused on sharing thoughts and feelings and (2) decision making or problem solving. These guidelines are presented as recommendations, not as rigid rules, altering the guidelines according to the needs of each couple and how they might talk to each other in more natural ways rather than as a stilted conversation following a set of written rules. A detailed delineation of these communication guidelines and nuanced alterations to meet the needs of specific couples is provided elsewhere (Baucom et al., 2020; Epstein & Baucom, 2002). A brief overview of partners' roles and the guidelines for these two types of conversation are provided below.

Sharing Thoughts and Feelings Conversations. The aim of sharing thoughts and feelings conversations is to create a context in which (1) both individuals share their thoughts and feelings in an appropriate way and (2) the other person listens attentively, with the intention of understanding the partner's perspective without judgment, and showing the partner understanding, expanding on what has often been referred to as "speaker–listener" guidelines. In the "speaker role," the individual seeks to identify and label internal experiences and communicate them in a way that increases the likelihood that the partner will be able to listen and understand without feeling attacked or becoming defensive, even if the listener disagrees with the speaker. This involves, for example, the speaker speaking subjectively and including their own feelings about the situation. In contrast, the listener is to demonstrate genuine interest and acceptance of the speaker's right to their perspective, reflecting the speaker's most important thoughts and feelings without judgment. Speaking in a caring manner to one's partner and listening receptively is fundamental to healthy relationships, and many couples report that this is one of the most valuable aspects of couple therapy. See Table 3.1 for specific guidelines.

Decision-Making and Problem-Solving Conversations. Couples also need to make good joint decisions and solve problems, including managing practical aspects of their lives effectively, such as household chores and finances, or making decisions regarding emotional aspects of the couple's relationship (e.g., how to provide emotional support when one partner is struggling). Couples can benefit from considering the following guidelines while making decisions (see Baucom et al., 2020, for detailed guidelines): (1) defining the issue; (2) clarifying why the issue is important and what each person hopes for in relation to the situation; (3) generating possible solutions that attend to both partners' wishes and needs; (4) choosing a solution and creating a plan of action; and (5) when appropriate, selecting a trial period to try out the solution.

These guidelines focus on the process of how to communicate. In addition, the therapist should attend to the content of relationship themes and issues the couple discusses, helping ensure that these topics are addressed in ways that are consistent with overall treatment goals.

If designed well and based on the case conceptualization, behavioral interventions often influence both partners' cognitions and emotions. For example, improved communication often leads partners to view each other as more respectful and caring. In addition, interventions directly addressing cognitive and emotional factors are of great value.

Interventions for Modifying Cognitions

In addition to behaving overtly, partners *experience* their relationship internally, including both their cognitions about what has occurred

TABLE 3.1. Communication Guidelines for Sharing Thoughts and Feelings

Guidelines for the speaker

Share your thoughts and feelings in a way that makes it as easy as possible for your partner to listen and understand.

- Talk about your experiences subjectively, not as absolute truths.
- Include your emotions or feelings.
- Make your statement specific (describe specific feelings, thoughts, behaviors).
- Speak in "paragraphs." Give your partner a chance to respond to one idea at a time.
- When you share negative feelings or concerns, include positive feelings you have as well.
- Describe how you feel about your partner and not just an event.
- Express yourself with tact and timing.

Guidelines for the listener

Focus on understanding your partner's experience, and help your partner feel understood.

- **Put yourself in your partner's place. Think about the situation from your partner's perspective, without adding your own opinion.**
- **Show that you understand and accept what your partner says, even if you do not agree. Acceptance is *not* agreement.**

When your partner finishes speaking . . .

- Summarize your partner's most important feelings, desires, conflicts, and thoughts in a way that shows you truly listened.

Do not . . .

- Express your own opinion.
- Judge your partner.
- Change the meaning of what your partner said.
- Jump to problem solving.

and with emotional reactions. Addressing cognitions in a couple context is made more complex because the two partners' cognitions (e.g., standards for expressing caring) often differ. Thus, the therapist must be respectful of partners' differing cognitions without suggesting that either partner's experience is the "true reality." To this end, cognitive restructuring with couples relies less on Socratic questioning, which often includes direct questioning and asking for evidence about one person's cognitions. Such a strategy can easily lead to defensiveness and an experience that the therapist is siding with the other partner. Instead, the therapist relies more on *guided discovery,* which involves creating new experiences in which partners come to see each other and the relationship in different ways, leading to cognitive change. These cognitive interventions often focus on either *how* the relationship and events are processed or *substantive aspects* or content of each individual's cognitions.

INTERVENING WITH COGNITIVE PROCESSING

Within healthy relationships, each person attends to what is occurring in a well-balanced manner rather than selectively attending to negative aspects of the situation, which is common in distressed relationships. Likewise, when appropriate, a given experience often is viewed with an interpersonal lens, understanding how each person influences the other and when one person might act to improve the relationship, what we have referred to as relationship *schematic processing* (Sullivan & Baucom, 2005). At times, interventions are employed to facilitate more adaptive processing in these areas.

To counteract selective attention to negative aspects of the relationship, the therapist can emphasize a more balanced focus on relationship events in a variety of ways, creating specific interventions as needed. For example, the therapist might ask the couple to write down one positive thing that the partner does each day. This effort might be extended into an interpersonal process by having each person express appreciation for the other's behavior. Similarly, within session, the therapist might ask a couple to reflect on what went well during their conversation rather than focusing on what went poorly.

With regard to improving relationship schematic processing, the therapist emphasizes the interconnectedness between the two persons' behaviors. For example, the therapist might ask each partner, "What do you think you as an individual did well during the conversation, and how did it help make things better?" This interpersonal perspective can be incorporated into many interventions. For example, while sharing thoughts and feelings, the speaker is encouraged to describe how they feel when a partner behaves in a given way, pointing out how the partner's behavior influences the other's emotions.

INTERVENING WITH COGNITIVE CONTENT

The therapist also addresses the content of a person's cognitions about the relationship. This includes automatic thoughts about specific events (i.e., attributions about causes of what has occurred and expectances regarding what will occur in the future), as well as more basic beliefs about the relationship (partners' assumptions about how their relationship actually operates and their standards for how each partner and the relationship should proceed). Even though interventions for each of these types of cognitions differ, the guided discovery process involves the couple having experiences inside and outside of sessions that provide additional information and context for shifting cognitions as needed.

For example, often individuals make negative, distress-maintaining attributions for their partner's previous behavior, based on "mind-reading," without checking their interpretations with the partner. Interventions that provide new information from the partner or others about the bases of the partner's behavior can be of assistance. Thus, the couple can have a conversation in which each person shares their own thoughts and feelings, clarifying what each person was experiencing at the time of the event: "I had just had a very difficult conversation with a colleague at work and was totally preoccupied with what had happened. It wasn't that our dinner together was unimportant to me; I was just totally distracted but had not brought it up because I didn't want to focus on work during our time." Or instead of focusing on failed past experiences (e.g., ineffective attempts to enjoy leisure activities together), the therapist might help the couple plan changes that would be more successful and to give it a try. In this instance, the therapist is providing opportunities for an individual to experience different outcomes with a partner in order to change expectancies about the future.

In addition to partners' cognitions about specific events, they also hold relatively stable beliefs about their relationship, including assumptions and standards. Assumptions are based on a wide range of experiences and are not changed quickly. Thus, they are best targeted by addressing specific examples of relevant couple interaction as noted earlier, pointing out new behaviors that are inconsistent with an existing negative assumption. For example, if a person makes a concerted, ongoing effort to be more attentive, engaged, and responsive during conversations, over time the partner might come to hold a different assumption about the individual's level of caring. The therapist's role is to help structure these behavior changes and make certain that the broader pattern of change is noted.

Finally, couples might experience difficulties when one partner holds extreme standards for how a relationship should operate (e.g., "We should never get upset with each other"), the partners hold differing standards, or they hold similar standards that skew their relationship (e.g., "We should always put off having fun until all work is done"). In such instances, the therapist's role is to help the couple think about the standard more broadly, consider adjustments, and translate those altered standards into specific behaviors. This typically involves helping the couple (1) articulate their standards, (2) evaluate the pros and cons of such standards, (3) consider even small alterations in the standards that might provide most of the benefits of the original standard yet have fewer detrimental effects, (4) translate these broader standards into specific behaviors, and (5) learn to tolerate differences when they cannot be reconciled. For example, Dante and Marion (who always put others first) might conclude that giving to others remains an important principle but recognize that giving to each other also is essential and decide how to spend time together each week.

In all of the instances described earlier, the therapist maintains a collaborative, empirical, and inquisitive approach with the couple, encouraging them to be open to new input, to remain attentive to their own tendencies to experience the partner in certain ways, and to experiment with new behaviors to see what potential they might have as a couple. When conducted in this way, cognitive interventions are experienced by the couple not as an intellectual exercise or to challenge the legitimacy of their thinking, but rather as an integral process of exploration, along with attending to important behavioral and emotional aspects of their relationship.

Interventions for Modifying Emotional Experience and Expression

Addressing emotional factors in CBCT is central to conducting effective therapy sessions, as well as being an essential part of couples' well-being. First, creating an appropriate emotional tone in sessions is important for the sessions to flow well, even if the primary aim is to address cognitions or behaviors. Approaching almost any therapeutic task in session is difficult if one or both partners are emotionally dysregulated or withdrawn. Second, regarding a couple's overall well-being, it is important to help both partners experience and express emotions in a manner that contributes to achievement of the couple's immediate and long-term goals (e.g., increasing feelings of intimacy and security).

Interventions focused on emotions can target three aspects of the experience and expression of emotions: (1) the type of emotion, (2) the intensity of emotion, and (3) the emotional responsiveness of the two partners to each other. For all targets, the ability to express and describe one's emotional experience verbally is essential; therefore, the format and skills for sharing thoughts and feelings conversations often are an important platform in which emotions are addressed in CBCT. Supporting partners to identify and label emotions in a more nuanced manner can help both with individual emotion regulation and facilitate mutual understanding. Interventions for emotions can be distinguished by their primary aims of (1) heightening the experience and expression of emotions, (2) managing or decreasing intense emotions, and (3) modifying emotional reactivity/responsiveness between partners.

HEIGHTENING THE EXPERIENCE AND EXPRESSION OF EMOTIONS

Difficulties can arise when one or both partners experience emotions to a minimal extent, avoid expressing emotions, or express some emotions but avoid others. CBCT therapists utilize several interventions to heighten emotions that facilitate the therapeutic process or increase the overall intensity of emotions if they are minimized in a way that is maladaptive.

Particularly early in treatment, one or both partners might avoid expressing certain primary emotions that seem vulnerable (e.g., fear) and instead express stronger, less vulnerable secondary emotions such as frustration or anger (see also Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan). An important goal in such circumstances is to help the couple experience and express a wider range of emotions, including primary emotions. In order to encourage more open, vulnerable expression of difficult emotions, the therapist needs to create a safe environment, for example, providing structure and direction to ensure that neither person is punished for sharing something vulnerable. For example, a therapist might help the partner shape the attempt to be validating ("Michael, I know you experience this very differently and might feel an urge to explain this to Toby. But Toby has just shared something really difficult for him. Let him know that you have heard what he's going through—can you summarize what you heard about what this is like *for him*?"). Therapists also can contribute to a safe environment by providing psychoeducation to normalize and give permission, particularly if one partner appears to hold beliefs that an emotion is "wrong" (e.g., that feeling angry is a sign of immaturity).

Some partners might not selectively avoid certain emotions but rather have a muted experience or expression of all emotions, which can make the relationship feel devitalized. In such instances, the therapist can incorporate a variety of strategies that are also emphasized in emotionally focused couple therapy (see Chapter 6 by Johnson et al.). For example, a therapist might ask an individual to recount a past event in greater detail to evoke associated emotions; encourage an individual to avoid distraction from an emotion (e.g., intervene when the individual switches topics); use metaphors to access an emotion; guide the person through a mindful observation of bodily cues; and use questions, reflections, and interpretations to draw out primary emotions. Regardless of the specific strategy, the therapist's tone of voice and emotional expression can be an important tool in setting the overall atmosphere and accessing avoided emotions.

MANAGING OR DECREASING INTENSE EMOTIONS

While genuine expression of emotions can be important, dysregulated and intense expressions (particularly when associated with attacking behavior) tend to interfere with optimal relationship functioning. Therefore, a frequent task is to help the couple manage intense emotions, creating emotional safety in session and in the relationship more broadly. In session, CBCT therapists can increase the amount of structure in order to help contain intense emotions and prevent rapid escalation of interactions between partners. For example, therapists can ask partners to speak directly to the therapist rather than to each other, ask specific rather than open-ended questions, or explicitly instruct partners not to interrupt each other. The therapist can also help normalize and validate each person's emotional experience to help individuals feel heard at times when partners are less able to provide such responses to each other. The therapist also can decrease emotional arousal by focusing on the process of interaction versus the content and by generally using a more cognitive style in interacting with the couple. Typically, focusing on the content of what is distressing heightens emotional experience, whereas pointing out interactional processes from an observer perspective decreases emotions. For example, a therapist might note: "Let's pause for a moment and look at what just happened. We've been talking about both of your tendencies to switch into 'attack mode' when you feel hurt and then it escalates. Did you two notice that starting to happen just now?" The therapist could then help the partners think about a more helpful way of expressing their concerns and then refocus on content. In order to disrupt such patterns of rapid negative reciprocity, teaching guidelines for sharing thoughts and feelings also can be effective. Emphasizing the listener's task of summarizing what is heard contributes to a slower pace of interaction and minimizes misunderstandings that contribute to mutual attacks. Finally, the therapist can coach partners in using self-soothing techniques when they begin to become dysregulated in sessions.

CBCT therapists implement additional strategies to help couples manage intense emotions in their daily lives. For example, scheduling a regular time for the couple to talk about their difficulties can help contain negative feelings. Knowing that there is a designated place to share concerns can help prevent arguments occurring at other unhelpful times. Particularly early in therapy, arguments frequently arise in daily life; jointly developing a "time-out" plan to disrupt escalation can be helpful in these cases. Therapists can also aid in identifying additional coping strategies to help each individual contain frequent, intense negative emotions, such as journaling, self-care, or seeking social support from friends and family where appropriate.

In summary, the CBCT therapist employs a wide range of interventions to assist the couple both inside and outside of session to address myriad aspects of their emotional lives. Such interventions also must take into account a variety of important contextual factors such as cultural diversity in how emotions are expressed, along with other cultural differences.

Adapting CBCT to Address Cultural and Diversity Issues

In CBCT, general guidelines for clinicians developing cultural competence apply and are not discussed separately here; these include, for example, an in-depth understanding of the impact of the therapist's own cultural background on the approach to therapy and perspectives on relationships and the importance of attending to dynamics of power and oppression (Sue, Sie, Neville, & Smith, 2019). Many strategies for culturally competent individual therapy can be incorporated in a CBCT-consistent manner as well, such as drawing on existing frameworks for a multidimensional assessment of clients' cultural identities (Iwamasa & Hays, 2019), consistent with the contextual model of considering the individual, couple, and environmental levels in CBCT. As outlined earlier in the description of CBCT perspectives on relationship functioning, cultural factors are relevant to all aspects of the model, and therapists should be aware of major areas of cultural variation (e.g., regarding cognitions, behaviors, and emotions in relationships), as well as ways in which clients may be affected by systems of oppression (e.g., mental health implications of racism, barriers to treatment access). Consistent with the principles of collaborative empiricism and the overall open, transparent therapist style in CBCT, therapists should initiate conversations concerning cultural factors that might affect the couple's relationship, providing a rationale for why such questions are asked and attending to the implications of differences between partners or between the couple and therapist.

A variety of available treatment recommendations focus on traditionally underrepresented groups in couple therapy in general that are not specific to CBCT. These considerations include, for instance, how clinicians can help strengthen protective factors for African American couples coping with racism (e.g., Kelly & Boyd-Franklin, 2009; LaTaillade, 2006), adapt intervention strategies to be more consistent with specific cultures (e.g., Epstein et al., 2014), and address unique challenges for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) couples (see also Chapter 23 on queer couples, in this volume, by Coolhart), as well as considerations of intersectionality.

As one example more focal to CBCT that might generalize when working with other marginalized groups, Pentel and Baucom (2021) recently proposed a clinical framework for couple therapy with sexual minority couples, an adaptation of CBCT for female same-gender couples. They suggest that in order to provide affirming and effective CBCT treatment to sexual minority couples, therapists need to attend to (1) universal factors (relationship difficulties found across identities) that can be addressed using general CBCT principles, (2) sexual minority specific factors (e.g., stress experienced by members of minority groups resulting from discrimination, lack of social support, within-couple differences in terms of outness, internalized stigma), and (3) within-group diversity (e.g., recognizing the role of intersecting identities, as well as within-group differences, in how sexual minority couples approach their relationships). This framework can help therapists avoid either over- or underestimating how salient the partners' identities as a sexual minority may be in shaping their relationship. Based on the initial assessment, CBCT treatment can then be adapted to address relevant factors such as minority stress experienced by one or both individuals or the couple as a unit, as well as ways the couple may be able to respond to issues relating to internalized stigma or environmental stressors. These considerations will be most effective if therapists draw on other, general principles of affirming care, such as removing heterosexist bias from materials and language used in treatment (Pentel & Baucom, 2021).

While the specific content of the previous framework is focal to sexual minority couples, the broader framework has potential applicability for working with couples with other marginalized identities. With regard to most dimensions of diversity, there likely are universal factors that affect relationship functioning, factors unique to a given group, and a great deal of within-group diversity that highlights the need for an individualized assessment. Additionally, many couples experience some within-couple differences in one or several aspects of their identity.

In addition to considering specific content that might be (uniquely) relevant for some couples, it is also important to recognize the ways in which CBCT in its original form makes culturally informed assumptions about relationships that are rooted mostly in North American, White, non-Hispanic, middle-class values. For example, the communication guidelines include implicit messages about equal roles for both partners, as well as the value of open, direct expression of emotions. For couples who may find such an approach inappropriate or maladaptive (e.g., based on a cultural background in which such expression would be considered a burden to others and emotions are conveyed much more by implicit context), guidelines can be adapted accordingly. In any case, determinations of what is adaptive or maladaptive for a given couple should always be based on an analysis in collaboration with the couple, examining the consequences of particular behavior changes at the individual, couple, and environmental levels, then supporting the couple in determining what will be helpful for them.

Treating Psychopathology and Physical Health Concerns in Couples

Couple therapists frequently encounter couples in which one or both partners experience some notable individual psychological or physical health concern. In CBCT, such concerns are incorporated into the case conceptualization and treatment plan as a factor at the individual level when treating relationship distress. For both distressed and satisfied couples, another route involves *couple-based interventions for psychopathology*. In such instances, the primary goal is different from couple therapy as discussed thus far. Rather than focusing on improving the couple's relationship, the primary aim is to treat the psychopathology or health problem by integrating CBCT principles within couple sessions, emphasizing evidence-based treatment approaches for the disorder. The couple relationship may also be targeted when appropriate, but improving relationship functioning is not the major goal of treatment. Several of these approaches are discussed in Chapters 24 through 28, in this volume, focused on couple-based therapy for individual problems.

Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) differentiated three types of couple-based interventions for psychopathology or health concerns (the current discussion focuses on psychopathology, and similar approaches are employed when medical problems are addressed). First, in partner-assisted interventions, the partner is used as a coach to help the individual with the disorder make needed individual changes. In this instance, the couple's relationship is not the focus of change. For example, if one person has agoraphobia, the partner might support that person engaging in exposures that have been arranged with the therapist; the couple might also problem-solve on how to approach the exposure outing successfully. Similarly, partner-assisted interventions might include strategies such as behavioral activation for depression or assisting with distress tolerance strategies after meals in the treatment of anorexia nervosa. Leveraging the partners' involvement in this way makes no assumption about relationship distress or dysfunctional couple interaction patterns.

Second, the therapist might employ a disorder-specific intervention in which the couple's relationship is the focus, but only as the relationship influences the disorder or is affected by the disorder. In the example of agoraphobia, therapists might guide the couple in altering the roles they have developed in which the healthy partner has taken over responsibilities involving trips outside the home in order to spare the person with agoraphobia emotional distress. Such patterns of changing daily habits and roles, as well as other ways of attempting to reduce distress or symptoms in the short term (with inadvertent long-term effects of maintaining symptoms), have been termed *accommodation*, with applicability across disorders (e.g., Calvocoressi et al., 1995). During the course of therapy, the couple might shift roles such that the partner with agoraphobia now does the grocery shopping, hence building exposure experiences into daily life. Thus, the therapist helps the couple alter aspects of the relationship that are focal to the disorder, making no assumption of relationship distress.

For both of these types of couple-based approaches, interventions focused on cognition, behavior, and emotion similar to those used in CBCT can be adapted as needed. For example, guided behavior change and problem-solving strategies might be used to help couples shift their roles and responsibilities and reduce accommodation. Also, to the extent that the couple experiences relationship discord, *couple therapy* (the third form of couple-based intervention) can be of assistance as well because a distressed relationship can be a chronic, diffuse stressor that exacerbates individual psychopathology.

A comprehensive discussion of these interventions is beyond the scope of this chapter and can be found elsewhere for both psychopathology (Baucom et al., 2020) and health concerns (Baucom, Porter, Kirby, & Hudepohl, 2012), as well as reviews of the research support for their efficacy (Fischer, Baucom, & Cohen, 2016). Baucom and colleagues (2020) describe the clinical practice of couple-based interventions for individual psychopathology in more detail, with a particular focus on depression, anxiety disorders, obsessive–compulsive disorder (OCD), and posttraumatic stress disorder (PTSD). Published treatment manuals are available for cognitive-behavioral couple-based interventions for specific disorders such as PTSD (Monson &

Fredman, 2012; also see Monson & Fredman, Chapter 24, in this volume) and substance use disorders (McCrady & Epstein, 2009; see also Chapter 25 on alcohol problems, in this volume, by McCrady, Epstein, & Holzhauer). However, there are common elements in couple-based interventions for individual distress, as described below, applied to psychopathology.

PSYCHOEDUCATION

After the initial assessment, treatment often begins with psychoeducation for the couple about the disorder, its etiology, how it tends to play out in an interpersonal context (e.g., common impacts on relationships, interpersonal maintenance factors such as accommodation), and what treatment will involve, including roles for each partner. In this context, therapists can gather additional information from the couple (e.g., how they interpret or interact around specific symptoms) and counter possible misconceptions.

COMMUNICATION SKILLS TRAINING

Because couple-based treatments frequently require couples to address difficult topics and implement a variety of changes in their lives relative to the disorder, skills training for sharing thoughts and feelings and for problem solving provide a useful basis for subsequent interventions. For some couples, these conversations also help to counter maladaptive interaction patterns regarding the disorder (e.g., high levels of expressed emotion or avoidance and secrecy regarding the disorder).

PARTNER-ASSISTED AND DISORDER-SPECIFIC INTERVENTIONS

In most cases, these two approaches make up the major portion of treatment. As noted earlier, partner-assisted interventions might include exposure treatment or behavioral activation. Disorder-specific interventions typically involve attempts to reduce accommodation, address other maladaptive interaction patterns surrounding the disorder, and normalize or expand daily routines once the disorder imposes fewer constraints. Even addressing a given concern such as medication adherence in bipolar disorder might involve a variety of interventions. For example, the therapist might first ask the couple to share their concerns, then proceed depending on what was revealed, employing interventions such as psychoeducation (addressing misconceptions about the medication), problem solving (how the partner can help with medication reminders—a partner-assisted intervention), or help the couple reconsider their daily routines to minimize missed doses (*a disorder-specific intervention*).

COUPLE THERAPY

When applicable, therapists can employ traditional CBCT intervention strategies to address relationship concerns, thereby reducing relationship discord as a chronic stressor that likely impacts individual functioning, as well as increasing the likelihood that the partners can work together productively to address the disorder.

Addressing Specific, Complex Relationship Difficulties

From its inception, CBCT has focused on reducing negative interactions between partners, including both verbal and nonverbal forms of aversive behavior. Many of these behaviors are forms of "aggression" that inflict emotional and/or physical pain, and a large percentage of couples in clinic samples engage in mutual aggression (Jose & O'Leary, 2009). Consequently, couple-based interventions with psychological and mild to moderate physical partner aggression may be necessary, ethically justifiable, and effective in improving the quality of a couple's relationship and reducing aggression without provoking violence (see Chapter 17, in this volume, by Epstein et al.). Couple therapies for partner aggression generally target empirically identified risk factors for partner aggression: (1) reliance on automatic aggressive behaviors to express distress and influence one's partner; (2) deficits in behavioral skills for communication, problem solving, and seeking intimacy; (3) negative cognitions that justify the use of aggression; (4) poor emotion regulation; and (5) difficulties coping with life stresses affecting the couple (La Taillade, Epstein, & Werlinich, 2006). Programs based on CBCT commonly focus on these risk factors, and initial trials have indicated their positive effects (e.g., LaTaillade et al., 2006; see also Chapter 17 by Epstein et al.). Overall, clinical observations suggest that the interventions are effective because they not only address risk factors for aggression but also provide a high level of structure and active therapist intervention to interrupt ingrained aggressive patterns, hold individuals responsible for their own aggressive acts, and build relationship strengths.

Just as partner aggression often involves behaviors outside the bounds of acceptable relationship behavior, infidelity shares a sense of violation for many couples. The application of CBCT to treating infidelity also is noteworthy because it provides an example of how CBCT principles can be integrated with principles from other theoretical approaches (in this instance, insight-oriented approaches) to address particular challenges. Affairs can be viewed as major relationship betrayals that significantly disrupt partners' basic assumptions about their relationships (e.g., as safe and secure), their partners (e.g., as trustworthy), and themselves, resulting in emotional and behavioral symptoms consistent with posttraumatic stress reactions. Working from this trauma-based perspective, Baucom, Snyder, and Gordon (2009) developed an integrative approach to working with couples struggling to recover from infidelity (see also Chapter 18, in this volume by Gordon, Mitchell, Baucom, & Snyder). This model includes three major stages: (1) absorbing and addressing the traumatic impact of the affair, (2) constructing meaning for why the affair occurred, and (3) moving forward with life (together or separate) within the context of this new understanding. The integration of CBCT with insight-oriented approaches to couple therapy (Snyder & Balderrama-Durbin, 2012) is central in Stage 2 of treatment, focused on understanding proximal and distal factors that made the person who had the affair vulnerable to having it. A clearer understanding of these factors then helps to shape the interventions that are needed to promote change for the future, with these future-oriented interventions derived largely from CBCT. Initial evidence from open trials for this approach are promising and described in more detail by Gordon and colleagues in Chapter 18.

MECHANISMS OF CHANGE

A healthy couple relationship is one that contributes to the well-being of each partner, the couple as a unit, and optimizes the couple's interaction with the environment. In promoting such goals, the CBCT therapist employs the variety of behavioral, cognitive, and emotional interventions discussed throughout the chapter within the context of a strong therapeutic alliance. Thus, there is no single mechanism of change or curative factor because what needs to change in order to promote a healthy relationship varies from couple to couple. The therapist often is central in helping promote these changes.

The Role of the Therapist in Promoting Healthy Couple Relationships

The therapist has an essential role in helping the couple through not only expertise in the use of specific therapeutic techniques but also in the manner in which these interventions unfold. As discussed earlier, the therapist employs these interventions while adopting multiple roles, including educator, motivator, guide, collaborator, and facilitator. In doing so, the therapist also employs a full range of therapeutic responses such as reflecting, interpreting, self-disclosing, using humor, and so forth, all selected in the service of achieving goals consistent with the case conceptualization. Also, although CBCT is focused largely on helping couples become increasingly aware of current factors that are amenable to change, therapists who have understanding or insight into possible influence of historical (e.g., each partner's family upbringing) or more distant factors on the couple's pattern can be particularly helpful in promoting cognitive and emotional change. Thus, rather than delineating a specific range of appropriate therapeutic responses, the CBCT therapist selects among a wide range of options to achieve a desired goal, a form of functional analysis examining consequences of various therapeutic interventions.

The demands of couple therapy might also influence the ease with which a therapist conducts treatment and enjoys being a CBCT therapist, which can be important for long-term therapist motivation and resilience. The therapist must attend to a large number of factors in working with couples. Therefore, therapists who can synthesize a great deal of information in a clear, cogent manner are likely to meet these demands of CBCT. Also, the therapist must be able to respond to real-time interactions during sessions that often change rapidly. Therefore, therapists who can process and act quickly and clearly in the moment can be of particular assistance to the couple. Therapists who prefer to proceed in a slower, more contemplative fashion might find CBCT to be more difficult. Therefore, treatment matching might include both a consideration of what interventions will be most effective for the couple and the selection of a therapist who works well within the therapeutic environment of CBCT.

Empirical Evidence on Mechanisms of Change in CBCT

Finally, it is important to consider the empirical evidence regarding the centrality of behavioral, cognitive, and emotional changes in promoting healthy relationships. Almost all research to date has approached this issue in terms of predicting increased relationship adjustment or satisfaction. Attempts to isolate the mechanisms of change in CBCT in this regard have been few and have had somewhat mixed results. Early studies with small samples had insufficient statistical power to detect mechanisms of change, and contrary to predictions, changes in communication skills during CBCT did not predict treatment outcomes (Halford, Sanders, & Behrens, 1993; Iverson & Baucom, 1990). However, Christensen's more recent comparative outcome study of an early form of behavioral couple therapy with little emphasis on cognition and emotion (which they called traditional behavioral couple therapy [TBCT]) and integrative behavioral couple therapy (IBCT; Christensen et al., 2004; see also Chapter 4, in this volume, by Christensen, Dimidjian, Martell, & Doss) that used a larger sample, more frequent assessments, and more sophisticated data-analytic strategies provided insight into possible mechanisms of change in behaviorally based couple therapies (Doss, Thum, Sevier, Atkins, & Christensen, 2005). TBCT produced a notable amount of targeted behavior change during the first half of therapy; as anticipated, those changes predicted increases in relationship satisfaction halfway through therapy. During the second half of therapy, targeted behavior changes decreased, along with some corresponding decreases in relationship adjustment during that time, yet still resulted in notable overall relationship improvement from pre- to posttreatment. In addition, increased self-reported positive communication and decreased self-reported negative communication predicted changes in relationship adjustment in the expected directions. Furthermore, individuals' subjective acceptance of their partner's behavior was an important predictor of improved relationship functioning across the entire treatment. These findings indicate that targeted changes are important to successful treatment. Thus, improving communication and other noncommunication behavior change predicts changes in relationship adjustment. In addition, internal cognitive–affective changes such as acceptance of one's partner are important in improving relationship adjustment and may be more effectively addressed in CBCT (and other evolutions of behaviorally based couple therapy such as IBCT) compared to purely behavioral interventions.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT FOR CBCT

Given that current evidence suggests no significant differences between strictly TBCT and a broader CBCT in alleviating relationship distress (Roddy, Walsh, Rothman, Hatch, & Doss, 2020) and CBCT builds on earlier BCT models, the empirical statuses of these interventions are discussed together as the status of CBCT. CBCT is the most widely evaluated couple treatment, having been a focus of approximately two dozen well-controlled treatment outcome studies. CBCT has been reviewed in detail, including findings from specific investigations (e.g., Snyder, Castellani, & Whisman, 2006), as well as meta-analyses (e.g., Roddy et al., 2020). All of these reviews reached the same conclusion: CBCT is an efficacious intervention for distressed couples. More specifically, the results of these well-controlled investigations confirm that CBCT is efficacious in alleviating distress and improving communication for distressed couples. These effects have been found in fairly brief interventions, often as few as 8–12 sessions. Also, these findings seem quite generalizable, with replications across several continents with both experienced and student therapists.

Most couples appear to maintain gains in relationship adjustment for up to 1 year. Earlier investigations showed more discouraging long-term effects (e.g., Snyder, Wills, & Grady-Fletcher, 1991). However, a more recent investigation of TBCT demonstrates more promising long-term results. At a 2-year follow-up, Christensen, Atkins, Yi, Baucom, and George (2006) found that approximately 60% of couples receiving TBCT were improved relative to their pretreatment status, according to clinical significance criteria. A 5-year follow-up also demonstrated enduring effects for TBCT, with notable improvement in relationship adjustment from pretest to 5 years after treatment. Furthermore, the 5-year follow-up showed that TBCT and IBCT produced equivalent changes in relationship adjustment and divorce rate (Christensen, Atkins, Baucom, & Yi, 2010). For a discussion of the mechanisms that account for the changes observed in couple therapy and predictors of which couples respond to couple therapy, see Doss and colleagues (2005) and Snyder and colleagues (2006). Overall, the empirical status of CBCT is noteworthy. Across multiple randomized controlled trials across several continents, employing therapists with different levels of experience, CBCT has demonstrated consistent effects in improving relationship functioning.

As noted earlier, CBCT also has been applied in the treatment of individual psychopathology. Behaviorally based couple interventions targeting relationship distress have demonstrated efficacy in the treatment of depression (e.g., see Barbato & D'Avanzo, 2020, for a meta-analysis of several couple therapy models including BCT). More recent CBCT adaptations include a specific focus on depression and improved both depression and relationship satisfaction (Bodenmann et al., 2008; Cohen, O'Leary, & Foran, 2010; see also Chapter 26 on depression or anxiety, in this volume, by Whisman, Beach, & Davila), and an effectiveness study of CBCT for depression in routine clinical care showed improvements in depression and anxiety, and relationship satisfaction for the index patient (Baucom et al., 2018). As another application with extensive treatment research, BCT for alcohol use disorders has consistently been shown to be efficacious and either equal or superior to individual treatments on various alcohol and relationship outcomes within a given study (Fischer et al., 2016; see also Chapter 25 on alcohol problems, in this volume, by McCrady et al.). In addition, there are a number of investigations demonstrating that a couple-based approach to treating PTSD results in large reductions in PTSD symptoms, improvements in relationship functioning, and improvements in the other partners' mental health (see also Chapter 24 on PTSD, in this volume, by Monson & Fredman). Fewer trials are available for other disorders but are consistently promising in terms of efficacy and, where comparisons are available, are either equally or more efficacious compared to individual treatments, for example, for other substance use disorders, OCD, anorexia nervosa, binge eating disorder, and significant emotion dysregulation (Fischer et al., 2016).

Because the outcomes in studies on couple-based treatments for health concerns are more varied (e.g., psychological, relational, or medical), findings are more complex. However, overall, these interventions appear to be at least as effective as individual interventions and often have additional benefits in terms of relationship outcomes (Fischer et al., 2016). Couple-based interventions for couples coping with cancer have been most extensively evaluated, with fewer studies available for health concerns such as chronic pain, cardiovascular disease, diabetes, and HIV (Fischer et al., 2016).

CASE ILLUSTRATION

Julia (age 29), a Latina cisgender woman, and Mark (age 29) a White cisgender man, have been married for 5 years and have a 3-year-old daughter, Sofia. They contacted a couple therapist based on Julia's urging, following her disclosure to Mark that she had become so discouraged about distance between them that she had been thinking that they should separate. When Julia contacted the therapist by phone, the therapist (a 40-year-old White cisgender woman) conducted an initial screening regarding the appropriateness of couple therapy. After an initial telephone contact, the therapist sent the couple assessment questionnaires to complete independently at home, including a relationship satisfaction scale, measures of psychological and physical partner aggression, and a measure of psychopathology symptoms. The therapist's review of the partners' questionnaires indicated significant relationship distress (higher for Julia), mild depression and anxiety symptoms for both individuals, and low levels of mutual psychological aggression involving hostile withdrawal and denigration of each other.

During the initial conjoint assessment interview, the therapist asked Julia and Mark to describe the concerns that brought them to couple therapy, followed by a brief history of their relationship, how they interact on a daily basis (including their patterns when they are in conflict), a more detailed discussion of current concerns and strengths, and what they had tried so far to resolve their issues. Regarding their presenting concerns, Julia stated that early in their marriage, it seemed that Mark was irritable with her and was distancing himself from her, especially when she tried asking him to talk with her about their relationship. In turn, Mark stated that he was increasingly frustrated that Julia was so absorbed with their baby, her job, and her family of origin that she had little interest in his life and stresses. They agreed that whenever they discussed their relationship, it quickly deteriorated into escalating mutual criticism, then withdrawal from each other to avoid further conflict. This negative pattern contrasted sharply with their portrayal of the beginning and early years of their relationship. They met in a class during their junior year at the local university they both attended. They became friendly in class and transitioned to dating, enjoying each other's company and their shared experiences in sports, as well as interests in politics and social issues. They both had participated in sports most of their lives, and Mark had continued as a reserve on the college basketball team, being viewed as having limited skills but a real mind for the game. His coach hired Mark as an assistant coach upon his graduation, a position that made Mark quite happy initially. After graduation, Julia completed a social work graduate program and was hired at a local social service agency, a job she valued. Their bond strengthened, and after graduation, they moved in together, soon became engaged, and a year later they were married, at age 24. Sofia was born 2 years later. Because both partners' families of origin lived close by, the couple had some assistance with child care from their parents, but with their jobs and young child, life was hectic.

During the couple assessment, the therapist learned that although both partners began their professional careers and their family life on a positive note, over the years, they felt that their life trajectories tended to diverge. Mark stated that he had believed he would be fulfilled by staying connected to basketball through coaching, but he increasingly became aware that he had always been disappointed at being a reserve on the team and watching some teammates go on to play professionally; continuing as an assistant coach to watch young players excel was deflating. He realized that the path to obtaining a head-coaching job was difficult and became discouraged about his future. In contrast, Julia felt fulfilled and happy with her life as a social worker assisting people in need, being a mother, and having a close-knit family of origin, although she increasingly worried that her bond with Mark was slipping. Both partners said that they loved each other but felt disconnected from each other. Mark said that separating had crossed his mind, but he was surprised when Julia revealed how unhappy she was.

In her individual interview, Julia noted that in her family and, more generally, coming from her Latino background, she was accustomed to relying on close family relationships and sharing of feelings, but that level of connection seemed limited with Mark. In fact, he had expressed resentment at her close relationships with her parents and sisters. She told the therapist that given how well she and Mark had gotten along during their early years together, she did not expect the distance that emerged when it came to dealing with and expressing feelings about life stresses. At the same time, she also described feeling some pressure to "keep the peace" (something she noted was a common role that other women in her family took) and avoid expressing how unhappy she truly was in order to prevent further conflict and keep the family together. During Mark's interview, he described his family of origin as loving but not emotionally expressive. He knew his parents had been proud of his academic and athletic success in high school and college but wondered whether he was disappointing them with his current job, although he could not imagine asking them. He said that he was happy for Julia but felt some envy that she was doing exactly what she wanted in her life. He also noticed how happy she was when interacting with her family and with Sofia, in contrast to the awkwardness between the two of them, and he interpreted that contrast as meaning that Julia did not love or value him as much as the others in her life. Rather than expressing those vulnerable feelings to her, he had started to avoid her or express irritation.

Based on the information she collected from the questionnaires, joint assessment interview, and individual interviews, the therapist formulated a case conceptualization that focused on (1) differences between the partners, such as communication styles and family relations that were in part culturally based; (2) stressors associated with developmental changes in the partners' individual life trajectories, as well as couple life stage and the couple's difficulty in coping with them; (3) Mark's individual self-esteem issues associated with his evaluation of his level of success in life, combined with his tendency to compare himself with Julia and her relationships with other family members; and (4) an interaction pattern involving Julia pursuing Mark for communication and connection, while Mark withdrew from her. However, when it came to their limited finances, Julia felt that they had to talk and make decisions, so she would push, and then Mark felt inadequate and lashed out at her in order to end the conversation. Given the increasing conflict and distance between them, combined with increased relationship distress and hopelessness they have been experiencing, the therapist considered the couple to be at a pivotal point at which intervention was crucial. She met with the couple to share feedback regarding her assessment and case conceptualization, and both partners reported that they found the feedback to be very relevant. They agreed to meet weekly for therapy for 2 months to use a variety of CBCT interventions to work toward those goals, at which point the three of them would evaluate the level of progress and make a decision regarding further therapy. The initial goals were (1) to improve their ability to communicate about their thoughts and emotions in order to increase their sense of connection, mutual caring, and mutual emotional support, taking into account differences in their accustomed communication styles based on their personal backgrounds; (2) to improve their problem-solving skills to address stressors in their daily life such as finances and competing work and family role demands, as well as an exploration of Mark's career options; (3) to increase their abilities to monitor and intervene with their cognitions about each other, such as Mark's attributions about Julia's level of caring about him versus other people and roles in her life; and (4) to alter their pursue–withdraw behavioral pattern and increase shared positive activities (more like the enjoyable experiences earlier in their relationship) to facilitate a more positive connection.

For each of the therapy goals, the therapist integrated interventions for the partners' behavior, cognitions, and emotional responses as needed. Thus, Julia and Mark were not only taught expressive and empathic listening skills to facilitate their communication, but their cognitions about appropriateness of expressing vulnerable feelings, such as Mark's anxiety and guilt regarding his life achievements, were also addressed during the skills training. The developmental changes in both their individual life trajectories and in the circumstances in their couple relationship were discussed in detail, and the therapist coached them in brainstorming potential solutions to the problem they faced in the loss of their previous mutually enjoyable shared leisure time and long discussions of interesting topics. As is often the case in CBCT sessions, the therapist closely monitored cues of the partners' reactions to each other's behavior, exploring their cognitions and emotional responses in the moment. For example, when Julia described how she found it stressful to balance her job and responsibilities at home but "wouldn't trade this life for anything," the therapist noticed Mark's restless behavior and facial expression and asked him what he was thinking and feeling. This type of intervention helped Mark and Julia become more attuned to both the process and content of their discussions. In this instance, Mark noted that Julia's comment meant to him that her life was perfect to her, in contrast to his unsettled life. He felt anxiety that she might be able to have a successful and happy life without him, particularly given that he felt he was not contributing what he should financially. He also revealed that this distress made him wish he could leave the session. The therapist guided Mark in seeing how his inferences about the meaning of Julia's statement had strong effects on his emotions and behavior, a pattern that was playing out at home as well, including his withdrawal or hurtful comments to back her off (which actually exacerbated the tension and distance between them, and further contributed to Julia's tendency to self-silence after aversive interactions). Additionally, to counteract the couple's pursue–withdraw pattern, the couple and therapist decided that each of them would initiate a leisure activity that they would share during the coming week, with options selected as realistic to carry out during a typical busy week. When Julia voiced concern about "forcing us together when it has been so uncomfortable between us," the therapist explored her negative expectancy that the experience would end poorly and explored with both partners how they could lower the pressure about how they are "supposed to" feel in order for the shared time to be considered worthwhile in starting to change their long-standing disengagement. This was an example of troubleshooting barriers to the couple carrying out homework tasks that could shift their problematic interaction patterns.

Given that Mark's personal distress regarding his career was both an individual issue and a stressor on the couple's relationship, the therapist discussed with the couple both interventions that could reduce Mark's distress that would involve them as a couple, as well as interventions that he could pursue on his own. Thus, the therapist first asked the couple to hold a discussion in which Mark expressed his personal distress and sense of failure while Julia attempted to provide some emotional support. Initially Mark balked at this suggestion, disclosing that it made him feel even more inferior in Julia's eyes. The therapist had Mark explore evidence regarding Julia's actual appraisal of him (including her direct feedback in the session that she respected his work and that she viewed their income as a joint responsibility; she only felt bad that he was dissatisfied himself). The therapist also encouraged Julia to share some of her own challenges at her work (e.g., feeling overwhelmed at times), which she was hesitant to share when the atmosphere at home was already down. Hearing about Julia's own struggles also helped Mark realize that Julia was not leading a "perfect" life outside of their relationship, which also increased his own comfort in sharing his difficulties. As Mark felt more accepted by Julia with regard to his career difficulties, he expressed increased interest in thinking more about his career goals. The therapist suggested that he could pursue some individual therapy sessions to explore his career interests, values, and options on a personal basis. They then discussed how he would then include Julia in further discussion and joint decision making as he became clearer about his possible next steps.

Even though the couple improved in being able to discuss difficult issues in session, they reported that their most difficult topics, such as finances, still led to arguments at home. The therapist then led the couple through a problem-solving discussion to decide how they might approach difficult topics, particularly financial issues, in their daily lives. Mark noted that he wanted them to tackle their difficulties as a team, but he was often taken off guard when Julia brought up problematic areas. Julia noted that bringing the topic up was unpleasant for her as well but she did not know what else to do. Therefore, the couple agreed to set a specific time twice a month to discuss their finances, as well as other issues, so that each of them would be aware and prepared for the discussions. They also agreed that it would be best to pick a time when Sofia was at her grandparents' house, so they would be uninterrupted, to set a time limit to avoid these conversations feeling too overwhelming, and to decide what the signal and steps for a "time-out" would be if the discussion became too heated. This plan also helped to further decrease the couple's approach–withdraw dynamic.

The structure and focus of the CBCT interventions that were closely tied to the couple's presenting problems, assessment information, case conceptualization, and therapy goals contributed to Julia and Mark making concrete changes that gradually reduced their hopelessness about their relationship. Their increased mutual understanding and acceptance of influences of their personal histories, including cultural differences in communication styles and experiences of close relations, increased their comfort with each other. After 2 months of weekly joint sessions, plus an individual session with Mark to discuss his goals in initiating concurrent individual therapy with another clinician, the therapist and couple conducted a collaborative evaluation of the degree of progress toward achievement of each therapy goal. They agreed that significant progress had been made, but that a shift to biweekly sessions for at least another month would be helpful in consolidating their gains, especially because they still had a tendency to lapse into a pursue–withdraw pattern, particularly when they addressed issues that triggered Mark's feeling of inadequacy about his roles as a partner. After an additional two sessions across the next month, the couple and therapist agreed that the couple had solidified their progress and that termination was appropriate.

CONCLUDING COMMENTS

The CBCT model captures the complex interplay among behaviors, cognitions, and emotions in contributing to the quality and stability of couples' relationships. With this broadening of the model has come an expansion of the interventions used to address partners' difficulties as impacted by individual, dyadic, and environmental factors, attending to macro-level themes. Additional recent theoretical and empirical expansions have focused on the application of CBCT principles to the treatment of individual difficulties such as psychopathology and health concerns. Thus, CBCT has broad applicability, as well as a strong evidence base, to assist couples facing a variety of difficulties in their lives.

SUGGESTIONS FOR FURTHER STUDY

Baucom, D. H. (Therapist). *Enhanced Cognitive-Behavioral Couple Therapy* (2008). Produced by American Psychological Association, APA Psychotherapy Video Series.

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach.* Abingdon, UK: Routledge.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach.* Washington, DC: American Psychological Association.

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process, 55,* 423–442.

REFERENCES

Barbato, A., & D'Avanzo, B. (2020). The findings of a Cochrane meta-analysis of couple therapy in adult depression: Implications for research and clinical practice. *Family Process, 59,* 361–375.

Baucom, D. H., Epstein, N., Sayers, S., & Sher, T. G. (1989). The role of cognitions in marital relationships: Definitional, methodological, and conceptual issues. *Journal of Consulting and Clinical Psychology, 57,* 31–38.

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach.* Abingdon, UK: Routledge.

Baucom, D. H., Fischer, M. S., Worrell, M., Corrie, S., Belus, J. M., Molyva, E., & Boeding, S. (2018). Couple-based intervention for depression: An effectiveness study in the National Health Service in England. *Family Process, 57,* 275–292.

Baucom, D. H., Porter, L. S., Kirby, J. S., & Hudepohl, J. (2012). Couple-based interventions for medical problems. *Behavior Therapy, 43,* 61–76.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66,* 53–88.

Baucom, D. H., Snyder, D. K., & Gordon, K. C. (2009). *Helping couples get past the affair: A clinician's guide.* New York: Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Bodenmann, G., Plancherel, B., Beach, S. R., Widmer, K., Gabriel, B., Meuwly, N., . . . Schramm, E. (2008). Effects of coping-oriented couples therapy on depression: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 76,* 944–954.

Bronfenbrenner, U. (1989). *Ecological systems theory* (Vol. 6). Greenwich, CT: JAI Press.

Calvocoressi, L., Lewis, B., Harris, M., Trufan, S. J., Goodman, W. K., McDougle, C. J., & Price, L. H. (1995). Family accommodation in obsessive–compulsive disorder. *American Journal of Psychiatry, 152,* 441–443.

Christensen, A., Atkins, D. C., Baucom, B. R., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 78,* 225–235.

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology, 72,* 176–191.

Christensen, A., Atkins, D. C., Yi, J., Baucom, D. H., & George, W. H. (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 74,* 1180–1191.

Cohen, S., O'Leary, K. D., & Foran, H. (2010). A randomized clinical trial of a brief, problem-focused couple therapy for depression. *Behavior Therapy, 41,* 433–446.

Doss, B. D., Thum, Y. M., Sevier, M., Atkins, D. C., & Christensen, A. (2005). Improving relationships: Mechanisms of change in couple therapy. *Journal of Consulting and Clinical Psychology, 73,* 624–633.

Eldridge, K., & Christensen, A. (2002). Demand–withdraw communication during couple conflict: A review and analysis. In P. Noller & J. A. Feeney (Eds.), *Understanding marriage: Developments in the study of couple interaction* (pp. 289–322). New York: Cambridge University Press.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach.* Washington, DC: American Psychological Association.

Epstein, N. B., Curtis, D. S., Edwards, E., Young, J. L., & Zheng, L. (2014). Therapy with families in China: Cultural factors influencing the therapeutic alliance and therapy goals. *Contemporary Family Therapy: An International Journal, 36,* 201–212.

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process, 55,* 423–442.

Halford, W. K., Sanders, M. R., & Behrens, B. C. (1993). A comparison of the generalization of behavioral marital therapy and enhanced behavioral marital therapy. *Journal of Consulting and Clinical Psychology, 61,* 51–60.

Iverson, A., & Baucom, D. H. (1990). Behavioral marital therapy outcomes: Alternative interpretations of the data. *Behavior Therapy, 21,* 129–138.

Iwamasa, G. Y., & Hays, P. A. (Eds.). (2019). *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed.). Washington, DC: American Psychological Association.

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles.* New York: Brunner/Mazel.

Jose, A., & O'Leary, K. D. (2009). Prevalence of partner aggression in representative and clinic samples. In *Psychological and physical aggression in couples: Causes and interventions.* (pp. 15–35). Washington, DC: American Psychological Association.

Kazantzis, N., Dattilio, F. M., & Dobson, K. S. (2017). *The therapeutic relationship in cognitive-behavioral therapy: A clinician's guide.* New York: Guilford Press.

Kelly, S., & Boyd-Franklin, N. (2009). Joining, understanding, and supporting Black couples in treatment. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp. 235–254). Thousand Oaks, CA: SAGE.

LaTaillade, J. J. (2006). Considerations for treatment of African American couple relationships.

Journal of Cognitive Psychotherapy, 20, 341–358.

La Taillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy, 20,* 393–410.

McCrady, B. S., & Epstein, E. E. (2009). *Overcoming alcohol problems: A couples-focused program.* New York: Oxford University Press.

Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for posttraumatic stress disorder: Therapist's manual.* New York: Guilford Press.

Pentel, K. Z., & Baucom, D. H. (2021). A clinical framework for sexual minority couple therapy. *Couple and Family Psychology: Research and Practice.* [Epub ahead of print]

Roddy, M. K., Walsh, L. M., Rothman, K., Hatch, S. G., & Doss, B. D. (2020). Meta-analysis of couple therapy: Effects across outcomes, designs, timeframes, and other moderators. *Journal of Consulting and Clinical Psychology, 88,* 583–596.

Scott, S. B., Whitton, S. W., & Buzzella, B. A. (2019). Providing relationship interventions to same-sex couples: Clinical considerations, program adaptations, and continuing education. *Cognitive and Behavioral Practice, 26,* 270–284.

Snyder, D., Wills, R., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy. *Journal of Consulting and Clinical Psychology, 59,* 138–141.

Snyder, D. K. (1997). *Marital Satisfaction Inventory—Revised.* Los Angeles: Western Psychological Services.

Snyder, D. K., & Balderrama-Durbin, C. (2012). Integrative approaches to couple therapy: Implications for clinical practice and research. *Behavior Therapy, 43,* 13–24.

Snyder, D. K., Castellani, A. M., & Whisman, M. A. (2006). Current status and future directions in couple therapy. *Annual Review of Psychology, 57,* 317–344.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38,* 15–28.

Stanley, S. M., Rhoades, G. K., & Markman, H. J. (2006). Sliding vs. deciding: Inertia and the premarital cohabitation effect. *Family Relations, 55,* 499–509.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283–316.

Stuart, R. B. (1969). Operant interpersonal treatment for marital discord. *Journal of Consulting and Clinical Psychology, 33,* 675–682.

Stuart, R. B. (1980). *Helping couples change: A social learning approach to marital therapy.* New York: Guilford Press.

Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Hoboken, NJ: Wiley.

Sullivan, L. J., & Baucom, D. H. (2005). Observational coding of relationship-schematic processing. *Journal of Marital and Family Therapy, 31,* 31–43.

Weiss, R. L., Hops, H., & Patterson, G. R. (1973). A framework for conceptualizing marital conflict, a technology for altering it, some data for evaluating it. In M. Hersen & A. S. Bellack (Eds.), *Behavior change: Methodology, concepts and practice* (pp. 309–342). Champaign, IL: Research Press.

CHAPTER 4

Integrative Behavioral Couple Therapy

Andrew Christensen, Sona Dimidjian,
Christopher R. Martell, and Brian D. Doss

BACKGROUND

Integrative behavioral couple therapy (IBCT), developed by Andrew Christensen and Neil S. Jacobson, has its roots in careful clinical observation and empirical research on the treatment of distressed couples. It is a contextually based behavioral treatment that has helped couples achieve improved satisfaction and adjustment as documented by both efficacy and effectiveness research. Although IBCT was first introduced in published form in an earlier edition of this *Handbook* (Christensen, Jacobson, & Babcock, 1995), detailed treatment manuals for therapists (Christensen, Doss, & Jacobson, 2020; Jacobson & Christensen, 1998) and self-help guides for couples were later published (Christensen, Doss, & Jacobson, 2014; Christensen & Jacobson, 2000), and a digital self-help program was developed (OurRelationship; *www.ourrelationship.com*). The additional materials can be used independently or in conjunction with in-person therapy.

IBCT focuses on broad themes and patterns in relationships. For example, a couple's struggles may center around the theme of trust with repeated patterns of interaction in which the untrusting partner questions or investigates the other's behavior, while the distrusted partner avoids those discussions and hides actions that might upset the other, even if those actions are innocent. Certainly, IBCT would seek specific behavioral examples of these themes and patterns, such as an argument the previous night about an old girlfriend. However, IBCT would focus on changing the pattern of interaction rather than changing a specific set of behaviors because there is an almost infinite set of possible behaviors in which a distrusting partner could question and investigate the other and an equally large set of behaviors in which a distrusted partner could avoid or detour discussions or disguise or hide actions. IBCT is interested in identifying a class of behaviors that may serve similar functions, such as the questioning and investigating behaviors of the distrusting partner that serve to reduce anxiety about the other.

Not only does IBCT focus on themes and patterns rather than target behaviors, IBCT includes a wide range of causal variables in its analysis. To understand a person's behavior, one certainly should consider proximal conditions such as the immediate antecedents for that behavior, the state of being of the person who behaves, and the proximal events that consequate that behavior. For example, in understanding a wife's deep sigh, we would note the husband's prior accusatory question, her being tired and stressed, and his subsequent angry repetition of the question. In addition to these proximal variables, IBCT also adds important historical and distal factors. For example, a man's history of being cheated on by a previous girlfriend may have created a suspicion or vigilance regarding his current partner's fidelity. Or the culture in which a woman exists may make it difficult for her to state her complaints directly.

The targets of change in IBCT include not only a change in behavior or in cognition about that behavior but they also include a change in emotional reaction or emotional acceptance of behavior. For example, if Bill thinks Mary is too critical, a positive change would be her becoming less critical and/or him construing her criticism differently (e.g., seeing it as her effort to be constructive). A change in emotional reaction or acceptance would mean that Bill reacts less strongly to Mary's criticism even if he doesn't like it or think it is constructive. In IBCT, we view most of the actions that trouble couples as not being egregious, such as violence or infidelity, so the difficulty lies not just in the provocative action but also in the emotional reaction. So the problem is not just that Mary is critical but that Bill is quite sensitive to criticism. Greater emotional acceptance of criticism, as well as reduced criticism, would be targets in IBCT.

Finally, IBCT relies on two broad strategies for bringing about change, what Skinner (1966) referred to as rule-governed behavior and as contingency-shaped behavior. In the former, the therapist brings about behavior change directly and deliberately by asking or instructing clients to engage in some behavior or by teaching them some new behavior. So, an IBCT therapist might help a couple develop a list of positive behaviors and instruct them to engage in those behaviors. Or a therapist might teach a couple communication and problem-solving skills and encourage them to use those skills when a problem arises. Although IBCT can employ rule-governed behavior change strategies such as these, it relies more heavily on contingency-shaped behavior strategies, which are behaviors that are not initiated by a deliberate rule or guideline but by the contingencies in the current environment.

For example, a husband might kiss his wife before going to bed because he is trying to respond to her request for more affection (rule-governed), or he might kiss her because he likes the way she looks or the way she flirted with him (contingency-shaped). Rather than teaching Mary communication skills so she can communicate her reactions less critically or having Bill monitor his thoughts about Mary's criticisms and try to make more benign interpretations of those criticisms, IBCT would engage Mary and Bill in a discussion about her comments, her urge to share with him her reactions to his behavior, how these comments affect Bill, his sensitivity to criticism, and the bind that both of them feel, such as her feeling she can never get her message across without offense and his feeling that he can never do much right in her eyes. When done well, this kind of conversation includes no suggestions or guidelines about how to behave or think but can soften partners to each other and enable them to be more responsive to each other in a contingency-shaped rather than rule-governed way.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

IBCT assumes that, over time, even the happiest and healthiest couples will face areas of difference and disagreement, which are assumed to be both normal and inevitable. Thus, distress is not caused by such differences, disagreements, or conflicts between partners. In contrast, distress is caused by the destructive ways that some couples respond to these inevitable incompatibilities.

In the early phases of a relationship, acceptance and tolerance of differences come easily to many couples. In fact, in many relationships, partners cite one another's differences as the source of their attraction. Lisa, for instance, may recall being enamored of Bruce's outspoken and direct nature, whereas Bruce may recall being impressed with the thoughtful way that Lisa considered issues, and her indirect and tactful way of expressing her opinions. Thus, during partners' early days together, differences are less often experienced as threatening or problematic for the relationship, and partners often find that their willingness to compromise with one another is high when such differences do create difficulty.

Differences between partners are likely to create difficulties when these differences spring from emotional sensitivities or vulnerabilities within each partner rather than mere differences in preference. Consider Bruce and Lisa's differences in directness and outspokenness. Bruce had a difficult first marriage and divorce with a woman he described as passive–aggressive and likely to undermine him at every turn. When Lisa's indirectness began to resemble what Bruce had found so upsetting in his first wife, he reacted very emotionally. For her part, Lisa felt that her father often bullied others, particularly her mother. When Bruce's outspoken manner began to resemble what she found so upsetting in her father, Lisa reacted emotionally. Thus, conflicts over their differences in expression were fueled by the vulnerabilities that Bruce and Lisa brought with them into the marriage.

External circumstances, particularly stressful circumstances, can exacerbate the differences that partners have with each other and the acuteness with which they experience their emotional sensitivities. For example, when Bruce is stressed by work and family life, he may be particularly outspoken and particularly impatient with Lisa's indirect style, while Lisa may be particularly passive when she is stressed. Thus, external circumstances can complicate the differences and emotional sensitivities that partners experience and can make it more difficult for them to adjust to each other.

Four destructive patterns frequently characterize distressed couples' conflicts over their differences: mutual escalating coercion, vilification, polarization, and alienation. Over time, as distressed couples experience an erosion in their willingness to accept, tolerate, and compromise around one another's differences, they no longer look upon each other's styles as sources of attraction; they begin to exert efforts to change their partners. Early on, these change efforts may entail direct requests and gentle persuasion. However, if these efforts fail, partners may resort to negative behaviors such as criticizing, withdrawing, yelling, and inducing guilt as attempts to change the partner or reduce contact. The most common of these negative, coercive strategies fall into one of three categories (Christensen et al., 2020): moving against the partner (e.g., criticizing, demanding, fault finding, or allying with others against the partner); moving away from the partner (e.g., avoidance, withdrawal, defensiveness), or hanging on to the partner (e.g., pursuing, hovering, invading the partner's privacy). According to coercion theory (Jacobson & Christensen, 1998; Patterson & Hops, 1972), these negative behaviors are often inadvertently and mutually reinforced. For example, Lisa may withdraw when Bruce's outspokenness is particularly upsetting to her; he may then respond to her withdrawal by being more solicitous with her; and Lisa may respond to his solicitous behavior by engaging with him again. Thus, her withdrawal is positively reinforced by his solicitous behavior; his solicitous behavior is in turn negatively reinforced (Lisa terminates her withdrawal). Over time, partners may shape each other into more extreme and persistent patterns of their coercive behavior. For example, Lisa does not get reinforced every time she withdraws, so she learns to persist with her efforts and to use more extreme withdrawal to get Bruce's attention. Also, both partners engage in coercion. Bruce may criticize Lisa for her indirection, and a similar pattern of mutual, intermittent reinforcement and shaping occurs. The couple creates a mutually escalating coercive system of interaction around their differences.

As these patterns of mutual coercion become more frequent and common, partners begin to see one another not as different but as deficient. In essence, they begin to vilify one another. Therefore, Lisa is no longer one who carefully considers things; instead, she is "controlling and withholding." Bruce, on the other hand, is defined not as direct and assertive, but as "impulsive and bullying." As vilification takes hold, each partner feels increasingly justified in their efforts to reform the wayward other.

As the differences between partners increasingly become a source of conflict, they tend to intensify or polarize; the chasm between the two partners grows wider and wider. In the face of the troubling behavior of the other, each partner exercises more and more of the behavior at which they are already proficient. Bruce becomes more forceful and outspoken; Lisa more withdrawn and uncommunicative. Each becomes more extreme in their actions. Their conflict serves to widen rather than to bridge the differences between them. They polarize. As their repeated efforts to solve their problems only create greater distress, they may withdraw from each other, hopeless to effect change. Now they have become alienated from each other. Therefore, through these processes of mutual escalating coercion, vilification, polarization, and alienation, distress is generated not just by the differences between partners but by partners' attempts to eliminate such differences.

In contrast to distressed couples, happy couples are able to confront their differences with greater emotional acceptance and tolerance. From a theoretical standpoint (Cordova, 2001), "acceptance" is behavior that occurs in the presence of aversive stimuli. It refers to responding to such stimuli not with behavior that functions to avoid, escape, or destroy, but with behavior that functions to maintain or to increase contact. From a couple's standpoint, acceptance means not being drawn into patterns of coercion, vilification, and polarization. Partners are able to maintain their positive connection despite—and, at times, maybe even because of—their differences.

What promotes acceptance in happy couples? Perhaps their differences are not as great; perhaps their individual personalities have fewer emotional vulnerabilities and are not as threatened by their differences; or perhaps there is greater social support for their union. These individual and contextual factors probably interact reciprocally with greater acceptance, so that, for example, greater acceptance in the relationship leads to the partners' feeling less threatened by their differences, which in turn leads to greater acceptance in the relationship. Existing research says little about the processes by which partners who, typically happy at the beginning, travel different trajectories, leading some couples to discord and separation, and others to stable and fulfilling unions.

THE PRACTICE OF IBCT

The Structure of IBCT

IBCT is typically provided in person in an outpatient setting and generally includes one therapist and the couple. Typically, neither other family members nor cotherapists are included, though nothing in the IBCT approach precludes doing so if such inclusions seem warranted by the needs of a particular case. Spurred by the COVID-19 pandemic, many therapists started providing IBCT through video formats.

The typical format of IBCT involves three initial evaluation sessions (an initial conjoint session followed by two individual sessions) and a fourth session devoted to feedback to the couple about the assessment and a description of the goals and methods of the active phase of therapy. A couple then makes a decision to engage in the active intervention phase of therapy which almost always consists of conjoint sessions and can go for varying lengths. In our empirical investigations of IBCT, we have used as a format a maximum of twenty-six 50-minute weekly sessions, which include the assessment, feedback, and active intervention sessions, with a final session or two devoted to summation and termination. However, from a conceptual standpoint, the structure and duration of therapy should be individually tailored to the needs of each couple. In general, the 50-minute weekly session format is well suited to many couples, since partners often need the continuity and intensity of this structure. However, it is important to note that other couples may elect to have less frequent meetings of the same or a longer duration (e.g., 2-hour sessions) due to demands of work or family life.

In IBCT, the duration of therapy and the timing of termination should be discussed collaboratively by the therapist and couple. The therapist should review with the partners their original presenting problems and the goals of each partner and should help them to assess the progress they have made. Because IBCT is based on the premise that differences and disagreements are a natural part of a couple's relationship, neither the therapist nor the couple needs to wait until all problems are resolved to decide to terminate treatment. If the partners are able to discuss issues more calmly, have a better understanding of one another's perspectives, and experience fewer distressing behaviors or are less distressed by those behaviors, therapy has been successful, and it is appropriate to begin discussing termination. Some couples may prefer to employ a gradual fading procedure or return for booster sessions, whereas others may not. In fact, there are no hard-and-fast rules regarding when or how to terminate; as with other aspects of IBCT, we believe listening carefully to the hopes and feelings of each partner is the best guide. Although the seriously and chronically distressed couples in our clinical trial (Christensen et al., 2004) averaged about 25 sessions, in practice, the number of sessions needed by couples ranges widely. Our long-term follow-up results did suggest considerable maintenance of gains during the first 2 years of follow-up but loss of some of those gains during the next 3 years of follow-up (Christensen, Atkins, Baucom, & Yi, 2010). Thus, booster sessions may be needed for many seriously distressed couples to maintain their gains over the long run.

Sessions during the active phase of intervention typically begin with an update on how the couple is doing in general with a specific focus on any concerning developments (e.g., an episode of violence, an alcohol- or drug-related event of concern, or any major changes in their lives such as loss of a job). Then, the therapist and couple develop an agenda based on issues or incidents that are most salient to the couple, such as the most important positive and most important negative interactions since the last session, an upcoming event that could be challenging for the couple, and any issue of current concern even if there hasn't been a recent incident related to it. This initial agenda can shift if more salient issues or incidents come to mind for the couple. These discussions, with the therapist as active facilitator, reflect issues germane to the formulation. For example, a couple might discuss an incident in which the wife left on a short business trip, if such partings reflect a problematic theme such as closeness and independence in the relationship; however, the couple would not typically focus on a positive parting (e.g., a warm kiss good-bye) or a negative parting (e.g., the husband's losing his way to the airport) if it did not reflect an ongoing relationship theme. The IBCT therapist is careful to reserve time at the end to help the couple achieve some closure on the topic and to highlight key points in the session, such as important revelations or agreements by the couple.

The Role of the Therapist

The IBCT therapist functions in different ways, depending on the context of a particular session. Although the IBCT therapist is frequently very active and directive in sessions, particularly in the early stages of therapy, the particular form of the therapist's interventions will vary. For example, with quite distressed couples, IBCT therapists may initially request that all the conversation go through them, so they can ignore parts of what each partner is saying, help each partner state their message in ways that are true to the messages but are stated in ways that the other can hear, and encourage the other to respond to those messages. At other times, IBCT therapists may encourage partners to speak directly to each other. In this way, being a good IBCT therapist requires comfort with a high degree of flexibility and change. In fact, it has become axiomatic among IBCT therapists that although it is essential to enter each session with a general plan or framework, there is nothing more important than a partner's most recent statement.

There are times, for instance, when the therapist may play the role of teacher or coach during a session, helping a couple to improve skills in communication or problem solving by working with them to shape their messages in ways that are less blame-focused and easier to hear and understand. At other times, the therapist may encourage the couple to use specific communication guidelines to have a conversation during the session, and then may provide feedback on the partners' performances. An important priority for the IBCT therapist is maintaining a focus on the case formulation of the couple (described below). In this sense, being a good and compassionate listener is one of the most important roles of the IBCT therapist. The therapist must be attentive to both verbal and nonverbal communications throughout the sessions and find skillful ways to maintain a focus on the couple's central theme despite myriad specific issues and complaints that may arise. To maintain a focus on the formulation, the therapist must also take care to do so in a way that expresses genuine understanding and empathy for each partner. Most often, the therapist is in the role of a caring facilitator, trying to discern the truth in each partner's communication and help them voice that truth in a way that is understandable to the other.

IBCT therapists are experiential guides, trying to balance change and acceptance techniques. Rather than teaching rules in a didactic fashion (e.g., akin to a classroom teacher giving a lecture), the IBCT therapist tries to provide the couple with a different experience in the session (e.g., akin to the same classroom teacher choosing instead to take students on a field trip). In general, the role of the IBCT therapist is to take a nonconfrontational, validating, and compassionate stance in interactions with the couple (Christensen et al., 2020).

Another role of the IBCT therapist is to attend to and highlight the *function* of behaviors. Often this requires that the therapist pay close attention to the function—rather than the content—of both verbal and nonverbal communications. For instance, Beth and Rick's therapist may be able to ascertain that Beth's frequent smiling and laughter during the couple's heated confrontations functions to express her anxiety about conflict, and her fear that Rick wants a divorce. The therapist's emphasis on the function of Beth's behavior may be in marked contrast to the couple's previous arguments over the content of Beth's behavior, which Rick interpreted as scorn and indifference.

Interestingly, paying attention to the function of behavior frequently requires the IBCT therapist also to play the role of historian with couples. Consider, for instance, the role played by the therapist of Carol and Derek. Carol complains that her partner, Derek, always goes directly to the sofa and reads the newspaper when he comes home from work. She is angry and frustrated because she would like to have time to interact with him. Derek, on the other hand, believes that he should have time to himself to unwind when he comes home from a very stressful day at work. The therapist recognizes that each partner feels isolated and blamed in this interaction: Derek feels accused of being lazy and disengaged, and Carol feels accused of being needy. The therapist also, however, has remained alert to salient historical information during previous interviews. The therapist may know that Derek's father died of a heart attack at the age of 46 and was a "workaholic," and that Carol's family never discussed issues and that she grew up believing her parents were not interested in her.

Using this historical context, the therapist may suggest that these histories have occasioned the current behaviors and associated feelings. The therapist may then solicit information about how

Carol and Derek felt during earlier times and ask whether they feel similarly now. Often this focus will promote softer responses and greater empathy on the part of both partners. Thus, instead of saying, "He never talks to me; he just sits around and reads that damned paper," Carol may reveal, "Yeah, when he is reading the paper, I feel lonely. It seems like that is what home always has felt like, and I didn't want that to happen in my own home when I became an adult. I just want to feel cared about." Instead of saying, "Why can't she give me a break? I work hard all day and I just want some peace and quiet," Derek may reveal, "You know, I saw Dad dog-tired every single day. He never stopped working, never took time for himself. He gave and gave to everyone, and it killed him. I am so scared that I'll turn into the same thing." The therapist, listening carefully, can then point out the theme of loneliness and isolation that is behind each partner's behaviors. Neither wants to abandon the other or to be abandoned. The therapist—as listener, mediator, and historian—can redirect the conversation in a fashion that allows the couple to talk about feelings, memories, and fears that are often obscured by the typical emphasis on accusation and blame.

Finally, a good IBCT therapist is also skilled at using language in a way that "hits home" (Jacobson & Christensen, 1998). The IBCT therapist uses language as an important intervention tool because impactful language is one important way to alter a couple's relationship context. The therapist should be alert to ways to incorporate metaphors and terms that hold meaning for the couple, and to increase the power of interventions and the likelihood that the couple will integrate the therapeutic ideas into their daily lives.

Assessment and Treatment Planning

A comprehensive and structured assessment process provides the foundation for all future interventions in IBCT. As noted earlier, the assessment phase includes an initial conjoint meeting with the couple and individual sessions with each partner and is followed by a conjoint feedback session in which the results of the assessment are discussed and a plan for treatment is developed.

Case Formulation

The primary goal of assessment is the development of a case formulation and a resultant treatment plan. In IBCT, the "formulation" comprises several primary components: the theme or themes; a DEEP analysis (see below) of the theme, including the polarization process; and the resultant mutual trap.

The "theme" describes a topic or category of conflictual behavior with similar functions. The theme is the broad class of behavior that serves as a basic unifying link among apparently disparate areas. In this way, the theme describes the group of behaviors in which each partner engages that serves a similar overriding function in the relationship. Thus, although the IBCT therapist continues to seek behavioral specificity in the assessment process, this aim is balanced by the need to attend to the *linkages* among problem behaviors. For instance, closeness–distance is one of the most commonly observed themes among couples seeking treatment, in which the closeness seeker may engage in diverse behaviors to seek closeness (suggesting joint events, questioning the partner's love when partner is not available for contact) and the distance seeker may engage in diverse behaviors to seek distance (withdrawal from the partner, accusing the partner of neediness when the partner presses for contact). Trust is another common theme in couples that may be manifested by diverse behaviors such as questions and interrogations or surreptitiously checking up on the partner. In understanding why a particular theme is so problematic for a couple, it is helpful to conduct a DEEP analysis of that theme. DEEP is an acronym for the primary components that, from an IBCT perspective, contribute to problems: **D**ifferences between partners because of their separate personalities, different cultural backgrounds, and so on; their **E**motional sensitivities that result from their separate histories and make those differences especially problematic; **E**xternal circumstances or stressors that exacerbate the differences or sensitivities; and finally the **P**attern of interaction that, rather than solving the problem, makes it worse. For example, Jack and Suzanna are fundamentally quite different in how much they want from a relationship. Except for the early period in their history, when they were both infatuated with each other and spent most of their free time together, Jack prefers more independence and Suzanna more connection. However, there are also some emotional sensitivities or vulnerabilities that make this theme so emotionally distressing for them. For example, Jack experienced his mother as invasive and smothering, and now experiences Suzanna in a similar way. He reacts to Suzanna's attempts at closeness as efforts by her to restrain his freedom. For Suzanna's part, her experience of growing up in a large family gave her the sense that she can never get the attention she needs.

She experiences Jack's response to her efforts at closeness as the kind of brush-off that has been painful throughout her life.

External circumstances, particularly stressors, may conspire to accentuate these differences and emotional sensitivities. For example, if Jack's work requires lots of stressful social interaction, while Suzanna's is much more solitary, then he may return home wanting to withdraw into himself, while she wants and needs conversation with him. Finally, the pattern of interaction refers to the efforts by the couple to solve the problem created by their differences, emotional sensitivities, and external stressors. Suzanna may well pursue Jack for more contact and may be critical of him when he is not responsive, suggesting that he does not love her. For his part, Jack may try to avoid or withdraw from Suzanna when she pursues him and may be defensive in response to her criticisms. This pursuing–distancing and critical–defensive pattern of interaction gives neither Suzanna the closeness she desires nor Jack the private respite from social contact that he desires. In fact, the pattern of interaction makes the problem worse. Jack and Suzanna may escalate their actions (Jack's defensive withdrawal, Suzanna's critical pursuit); their positions may become polarized (Jack desires even more alone time, and Suzanna desires even more close contact as a result of the struggle); they may vilify the other (Jack sees Suzanna as neurotically needy, while Suzanna sees Jack as pathologically afraid of intimacy); and they may become alienated from each other. The "mutual trap" refers to the effects of the pattern of interaction, highlighting the impact of the interaction process on both partners. Both partners feel stuck, discouraged, and hopeless—in a word, trapped.

A good formulation includes a careful description of the theme, a DEEP analysis of that theme, and the resulting mutual trap. However, its "goodness" depends on whether it is a helpful organizing concept for the couple—one that rings true to the partners, that the partners will integrate into their understanding of the relationship, and that will help to diminish blame and criticism and to increase their readiness for acceptance and change. In contrast, an unsuccessful formulation fails to serve as such a central organizing concept; the partners do not feel understood by the presentation of the formulation and do not integrate it into the basic vocabulary of the relationship, or they use it as a way to blame each other further. Although all formulations are modified and expanded in an ongoing and iterative fashion throughout the course of treatment, the core of the formulation is developed during the assessment phase of treatment. Both the structure and the content of the assessment phase have been carefully designed to facilitate the development of the formulation.

Overall, six primary questions guide the assessment phase and ensure that the therapist gathers information central to the development of the formulation:

1. How distressed is this couple?
2. How committed is this couple to the relationship?
3. What issues divide the partners (the theme or themes of the couple)?
4. Why are these issues such a problem for them (the DEEP analysis of those themes)?
5. What are the strengths holding them together?
6. What can treatment do to help them?

The therapist explores these questions during the conjoint and individual interviews, then summarizes the information during the feedback session. We discuss each of these components below.

The First Conjoint Interview

During the first interview, it is important to socialize the couple to the treatment model, establish trust, and instill hope. To socialize the couple, the therapist should explain the structure of the therapy, focusing in particular on distinctions between the assessment, feedback, and intervention phases of the model. The therapist can begin to establish trust and hope in the first session by exploring each partner's view of the problem and showing understanding of each one's feelings and position. The therapist often also instills hope by reviewing the couple's history, going over why they first got together and what keeps them together even now.

The overall goal of the first interview is to achieve a successful balance between a focus on the partners' presenting problems and on their relationship history. The therapist needs to understand what types of problems and conflicts have brought the couple into treatment, and partners usually want and expect to talk about their dissatisfactions and disappointments. It is critical that they leave the first session feeling heard, understood, and supported by the therapist, so typically a majority of the session is spent on presenting problems.

At the same time, however, the therapist needs to balance attention to these areas with a focus on the couple's history. Probing for information about how the couple behaves when things are going well, obtaining a history of initial attractions, and allowing partners time to talk about the time when their relationship was rewarding is critical for the development of the formulation. Moreover, focusing on these areas reduces the risk of increasing the couple's hopelessness, which may occur with an exclusive focus on the presenting problems.

When discussing the relationship history, the therapist should inquire about the partners' early attraction to one another. Often the initial attraction is a central component of the formulation because partners often find that the qualities that attracted them initially are the very same ones that later cause distress and conflict. Partners may be attracted by qualities they themselves do not have, such as when an emotionally stoic person is attracted to an emotionally reactive person, and vice versa. The mesh or synchrony between these complementary qualities may be positive at times, such as when the reactive partner adds color to the relationship and the stoic partner adds stability to it. However, these very qualities can also be disruptive when, for example, the stoic partner finds the emotionally reactive one grating, or the emotionally reactive partner finds the lack of response from the stoic partner frustrating.

To inquire about relationship strengths, the therapist asks about strengths present in the early phases of the relationship and asks what happens when things are going well. In addition, the therapist may focus on the couple's hopes for the future and ask how their relationship might be different if their current problems no longer existed.

Finally, we close the initial conjoint meeting by asking each partner to complete several relationship questionnaires and bring them to the individual session (described in Table 4.1 and discussed below). Although the are other questionnaires that assess similar constructs and provide greater detail, we usually rely on these as they are relatively short, easy to use, and freely available. We also may assign the first part of the IBCT manual for couples, *Reconcilable Differences* (Christensen et al., 2014). This reading assignment helps to engage the partners in the treatment process and further socializes them to the model. Couples often recognize themselves in the case examples, and the book may help them consider their problems in light of the formulation proposed by the therapist during the upcoming feedback session.

Individual Interviews

In IBCT, the therapist meets individually with each partner of the couple. These interviews begin with an explicit discussion of confidentiality. The therapist explains that the confidentiality agreement with the couple differs from such agreements characteristic of individual therapy, in that the therapist has a responsibility to both partners. In general, IBCT therapists explain to each partner, "Unless you tell me otherwise about a particular piece of information, I will assume that any information you share with me is okay to discuss in our conjoint sessions." Given this, the IBCT therapist agrees to maintain the confidentiality of each partner's private communications to the therapist. Sometimes partners communicate private information such as a history of sexual abuse, and the therapist can discuss with that person the pros and cons of sharing with their partner. If an individual communicates privately some information that is relevant to the current relationship, such as an ongoing affair or a decision to hide money from the partner, the

TABLE 4.1. Summary of Recommended Questionnaires

Couples Satisfaction Index (Funk & Rogge, 2007). Measures relationship distress. (To obtain this freely available measure, go to *www.courses.rochester.edu/surveys/funk*) and scroll down to Research Tools.)

Couple Questionnaire (Christensen, 2009). Brief screening assessment for couple satisfaction, intimate-partner violence, and commitment, as well as open-ended descriptions of typical positive and negative interactions. (To obtain this freely available measure, go to *http://ibct.psych.ucla.edu*.)

Problem Areas Questionnaire (Heavey, Christensen, & Malamuth, 1995). Assesses common problem areas or areas of disagreement in couples. (To obtain this freely available measure, go to *http://ibct.psych.ucla.edu*.)

Weekly Questionnaire (Christensen, 2010). Assesses significant positive and negative events since the last session, and includes a brief form of the Couples Satisfaction Index. (To obtain this freely available measure, go to *http://ibct.psych.ucla.edu*.)

therapist will keep this information confidential from the other. However, the therapist will ask the partner in question to resolve the issue (e.g., end an ongoing affair) or disclose the information to the other partner (e.g., tell the partner about the affair or the hiding of the money). If the individual cannot agree to the aforementioned options, the therapist should indicate that the individual cannot do couple therapy under these circumstances; that person is then left with the responsibility for communicating to the partner that couple therapy will not continue. This situation rarely occurs, as most partners understand the therapist's obligation to both parties and the difficulty of improving a relationship in the face of such important secrets.

During the individual interviews, the therapist gathers information about four primary areas: presenting problems and current situation; family-of-origin history; relationship history; and level of commitment. Other special assessment issues, which are discussed in detail in the following section, are also covered during the individual interviews.

In regard to presenting problems, the therapist may begin by referring to the discussion of presenting problems during the conjoint meeting and noting that partner's response to the open-ended question on the Couple Questionnaire (Christensen, 2009): "Please describe a recent interaction between you and your partner that is typical of the problems for which you have come to therapy." To ensure that all major problems are covered, the therapist may also note what the client checked off as the three most important problems on the Problem Areas Questionnaire (Heavey, Christensen, & Malamuth, 1995). A partner may neglect to mention a sensitive issue, such as sex, in the interview but may check that item on the questionnaire. The therapist should assess the interaction patterns that pertain to these major issues and be alert for polarization processes and/or traps associated with these issues. Discussion of an individual partner's family history should include inquiry about the parents' marriage, the parent–child relationship, and the general family atmosphere. In general, the therapist should be alert to possible ways these early relationships may serve as a model for the couple's current problems. The individual interview also provides an important opportunity for the therapist to review each partner's individual relationship history with previous partners. The therapist should be alert to similar patterns or problems in prior relationships, and/or ways that earlier relationships may serve as a possible model for the current couple's functioning.

The therapist also assesses each partner's level of distress and level of commitment to the relationship. The Couples Satisfaction Index (CSI; Funk & Rogge, 2007) is useful for measuring distress level. The commitment items on the Couple Questionnaire can be a helpful starting point for measuring commitment as each partner rates how much they want the relationship to succeed and what they are personally willing to do to achieve that success. The therapist can also assess each partner's understanding of their role in the current problems. Often it is helpful to ask, "How do you contribute to the problems in your relationship?" and "What are some of the changes that you need to make for your relationship to improve?" Answers to these questions help the therapist to determine the couple's degree of collaboration and commitment.

Feedback Session

The feedback session serves as the link between the assessment and treatment phases of IBCT. During this session, a summary of the therapist's understanding of the formulation is provided and a plan for treatment is outlined. The therapist solicits the couple's reactions throughout the session and frequently checks to make sure that the formulation is meaningful to both partners. If one member of the couple disagrees, the therapist asks for clarification, then incorporates the feedback into the formulation. Although the IBCT therapist wants the couple to buy into the formulation, the therapist needs to remain flexible—taking into account the partners' understanding of their own problems, and using the couple's words and ideas to present the main points of the formulation.

The structure of the feedback session follows directly from the six primary assessment questions that guide the first three sessions. First, the therapist provides feedback about the couple's level of distress. Toward this end, it may be useful to discuss the couple's scores on the CSI. Second, the therapist addresses the issue of commitment, again drawing from both the Couple Questionnaire and the individual sessions. In regard to both distress and commitment, the therapist needs to evaluate whether it is more advantageous to emphasize the couple's relative high distress/low commitment to highlight the gravity of the partners' problems, or their relative satisfaction/high commitment to assuage anxieties about their prognosis. Third, the therapist focuses on the issues that divide the partners, or their basic theme; the therapist refers to specific incidents that the partners mentioned in their joint or individual sessions and the specific items they noted on the Problem Areas Questionnaire to present the theme. Fourth, the therapist provides an overview of why these issues create such problems for the couple, using the DEEP analysis to explain how their differences, emotional sensitivities, and external stressors have made the problem so difficult and upsetting, and how their pattern of interaction has gotten in the way of their even discussing the issue constructively (much less making progress on the issue). Thus, they are often left feeling helpless and hopeless. Fifth, the therapist stresses the couple's strengths, often focusing on the partners' initial attraction to one another, as well as the current strengths that keep them in the relationship despite the problems.

Finally, the feedback session should include a clear discussion of what treatment can do to help the couple. During this part of the session, the therapist outlines broad treatment goals such as understanding and acceptance for their differences and emotional sensitivities but change for their patterns of interaction. The therapist also mentions specific treatment goals such as improving their cooperation in parenting. Then the therapist describes how treatment will progress by introducing the couple to the Weekly Questionnaire (Christensen, 2010), which they will complete before each session. This brief, one-page questionnaire asks about events that have happened since the last session and includes (1) a four-item version of the CSI (Funk & Rogge, 2007) to track the couple's satisfaction; (2) a question that asks (yes or no) whether any of the following occurred: violence or destructiveness, a problematic incident involving drug or alcohol, or a major change; (3) a question on the most positive, meaningful relationship event since the last session (e.g., "made love last Saturday night"); (4) a question on the most difficult or negative relationship event since the last session (e.g., "argument about trust yesterday"); (5) a question on any challenging upcoming event (e.g., "visit to her family over the holidays"); (6) a request to rank what is most important to discuss in this session (one of the events above or an issue unrelated to any particular event); and (7) any homework assignment. The therapist explains that this questionnaire will provide the content of their therapy sessions, and that the therapist will be active in helping them discuss these important relationship events and issues in a constructive way (i.e., by not getting back into their usual pattern of interaction).

Special Assessment Issues in IBCT

The assessment process may reveal particular clinical issues deserving of special discussion. There are few contraindications to IBCT; however, evidence of moderate to severe intimate partner violence, an ongoing and undisclosed extramarital affair, and/or significant individual psychopathology (e.g., one of the partners has a psychotic disorder or suicidal depression) may require a referral to another treatment modality. The individual sessions provide the primary context in which the therapist probes carefully to determine the presence of these issues.

In regard to intimate partner violence, the therapist should ask partners directly about the use of physical, sexual, and emotional abuse tactics. The therapist often begins an assessment of domestic violence with general questions about how the couple manages conflict (e.g., "What do you and your partner typically do to express anger or frustration?"), followed by questions that assess the consequences of the escalation of conflict (e.g., "Have you or your partner ever become physical during a conflict?" and "Are you afraid your partner might hurt you physically?"). Then the therapist may need to use concrete, behaviorally specific terminology (e.g., "Have you or your partner ever hit, shoved, or pushed one another?") because some partners will not endorse global constructs of "abuse" or "violence" even when specific acts have occurred. It is always important to attend to safety issues, inquiring about the presence of weapons and other relevant risk factors, as well as the possible presence and/or involvement of children during violent episodes. We strongly recommend the use of self-report questionnaires to assess for violence, such as the Couple Questionnaire, which is part of our usual packet of questionnaires for the individual session, because research suggests that wives are often more likely to disclose abuse in written, behaviorally specific questionnaires than on general intake questionnaires or during in-person interviews (O'Leary, Vivian, & Malone, 1992).

If intimate partner violence has led to injury, particularly in the last year, or intimidation, where one is afraid to speak their mind for fear of physical reprisal, then we strongly recommend against couple therapy (Christensen et al., 2020). Given that couple therapy can provoke discussion of volatile topics, couple therapy sessions may increase the risk of intimate partner violence. Moreover, the conjoint structure of IBCT may communicate to the couple that the responsibility for the violence is shared by both partners. For these reasons, we refer the abusive partner to a gender-specific domestic violence treatment program, and the victim to a victim service agency that provides support, safety planning, and legal services, if appropriate, or the couple to evidence-based violence prevention programs for couples (Stith, McCollum, Amanor-Boadu, & Smith, 2012; see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich). If the assessment of violence, however, indicates the presence of low-level aggression (in which partners do not report injury or fear), IBCT may be indicated. Our research has shown that such couples can be treated effectively (Simpson, Atkins, Gattis, & Christensen, 2008). In these cases, therapists should continue to use caution, monitor incidents of violence or destructiveness with the Weekly Questionnaire, and (as appropriate) insist on clearly stipulated "no-violence" contracts that specify detailed contingencies if violations occur.

During the individual sessions, therapists should also ask partners directly about their involvement in secret, extradyadic relationships, including both sexual relationships and significant emotional involvements. For example, the therapist may say, "When a couple is having difficulty, sometimes a partner will seek support or comfort in another relationship. Are you involved in such a relationship?" In general, IBCT is not conducted with couples committed to monogamy in which one partner is engaged in a secret, current, ongoing, secret affair. In such cases, the therapist recommends that the involved partner disclose the affair to the other and/or terminate the affair. If the partner is unwilling to follow this recommendation, the therapist refers the partner to individual therapy and ends couple therapy.

Finally, therapists inquire directly about the presence of significant psychopathology, including current or past experience of mood disorders, substance abuse, and other relevant psychological problems. As appropriate, therapists should inquire about major symptom criteria and the course of relevant disorders. In addition, current and/or past treatments should also be reviewed. In general, IBCT is often appropriate to treat couple issues when individual problems are successfully managed in concurrent individual psychological or pharmacological treatment, or when individual problems are closely tied to the problems in the relationship (e.g., depression as a result of marital discord). If there is evidence that a current episode of a disorder is not well managed by an ancillary treatment, therapists may want to consider postponing couple therapy and making a referral, so that an appropriate treatment targeting the disorder specifically can be implemented—including evidence-based couple interventions for specific disorders such as those included in Part III of this *Handbook*. See the IBCT treatment manual (Christensen et al., 2020) for further detail about handling intimate partner violence, affairs, and individual pathology in IBCT.

Goal Setting

The major treatment goals in IBCT can be understood through the DEEP analysis in the clinical formulation: to help members of a couple better understand and accept one another as individuals (i.e., accept their differences and emotional sensitivities), and to help them accept or change their external stressors as appropriate, but to assist them in changing their pattern of communication, so they can collaborate to solve the various issues and problems with which they are confronted and thus improve the quality of the relationship. The manner in which this overall goal is achieved differs for each couple, depending on the partners' unique presenting problems and history. Specific goals for treatment are determined collaboratively by the therapist and couple and are explicitly discussed during the feedback session.

Implicit in the goals of understanding, acceptance, and collaboration is the acknowledgment that staying together is not always the right outcome for all couples (see also Chapter 21 on divorce, in this volume, by Lebow). It is important for the IBCT therapist to work diligently with members of a couple to improve the quality of their relationship, while remaining neutral with regard to whether they should stay together or separate/divorce. In the context of a particular case, an IBCT therapist may help a couple consider the benefits and costs of staying together versus separating, for both the partners and their children, without communicating that they should try to save their relationship or that it is not worth saving. When IBCT therapists can help partners interact with one another, without the pressure of staying together at all costs or the fantasy that separation and new relationships will be easy, it may be easier for them to begin to understand the motivations and histories behind one another's behaviors, to be more accepting of those behaviors, and make some positive changes themselves.

Process, Techniques, and Strategies of IBCT

There are three intervention strategies used in IBCT: empathic joining, unified detachment, and direct or deliberate change strategies. The first two aim to increase acceptance but can bring about change; the last aims at change but can bring about acceptance. Each tries to bring about a different kind of conversation between partners to replace their usual pattern of interaction and to promote affective, cognitive, and behavioral change. In empathic joining, we try to bring about a compassionate discussion to promote emotional change; in unified detachment, an analytic discussion to promote cognitive change; and in direct or deliberate change, a practical discussion to promote behavioral change.

Empathic Joining

When a couple enters therapy, both partners are typically experiencing a great deal of emotional pain. Unfortunately, when they express their pain, they often do so with accusation and blame, which typically leads to defensiveness and counterattacks by the partner, thus exacerbating their distress. Therefore, the goal of empathic joining is to allow partners to express their pain in a way that does not include accusation. We shift the conversation away from the partner's provocative actions that upset them to the hurt that they experience. Or as we say in IBCT, we shift from the arrow to the wound (Christensen et al., 2020). Such a shift can lead to a more compassionate discussion wherein partners have a different emotional reaction to the other.

In IBCT, we assume that emotional reactions that are part of a long-standing struggle between partners are complicated and mixed. Certainly, partners often have easily accessible, often voiced, surface emotions such as anger and resentment about the other. However, they often have other, less accessible, hidden feelings and thoughts that are rarely or never voiced, such as guilt that they contributed to the problem, fear that they did not stand up for themselves, anxiety that the problem will end the relationship, and doubt that the partner really loves them. In IBCT, we validate the surface emotions but explore the hidden emotions with each.

As part of this process of exploring the hidden emotions, we often encourage "soft" rather than "hard" disclosures. Hard disclosures often express feelings of anger or resentment and may place the speaker in a dominant position relative to the listener. IBCT assumes that a corresponding soft side to most hard disclosures expresses the hurt and vulnerability behind the anger. In therapy, this is often referred to as getting the partner to talk about the "feeling behind the feeling." Using this metaphor, the therapist communicates to the couple that the public expression is not always the full picture of the private experience of each partner. Encouraging soft disclosures is done to soften not only the speaker but also the listener.

For instance, one partner might say, "You never take time to ask me how my day went. You're just concerned with yourself. Well, I'm sick of it." In this statement, anger, resentment, and accusation are resoundingly communicated. To encourage soft disclosure, the therapist might ask the partner what other feelings might also exist with the anger. Or, alternatively, the therapist might suggest a feeling by saying, "I wonder if you might also feel a little neglected . . . or maybe unimportant." The partner then might disclose a softer feeling by saying, for example, "I feel like my day doesn't matter to anybody. I spend all of my time taking care of others, and I feel so drained. I feel lonely and unappreciated." After validating those feelings and exploring them further, the therapist might then turn to the other partner, highlight the soft disclosure, and elicit feedback. The therapist might say, "I wonder if you are surprised that she/he felt lonely during these times?" Ideally, the listener will begin to soften and may respond with a similar soft disclosure—and a compassionate conversation, unlike the usual accusation–defense pattern, may emerge.

Another way of eliciting soft disclosures is to create a safe environment where couples can talk about their emotional vulnerabilities. In fact, it can sometimes be helpful for the therapist to point out mutual vulnerabilities in a couple. For example, Ellen and Craig have had frequent arguments about money and childrearing. The therapist is able to help each of them articulate their vulnerabilities in these areas. Both are very responsible people who want to be successful in their endeavors. Ellen takes primary responsibility for raising the children; therefore, she is very sensitive to doing a good job in this area. When Craig takes the children out for ice cream without first brushing their hair and making them look nice, Ellen becomes irate. He considers this an overreaction. However, Craig is very meticulous about money and wants to be a good provider for the family. When Ellen spends money that Craig does not anticipate, even just a few dollars, it leads to an argument. In this situation, Ellen sees Craig as the one who is overreacting. The therapist helps them express their mutual vulnerability to being less than successful in their respective roles, and the two of them are able to empathize with the reactions that initially seemed irrational and exaggerated.

We should note a final warning about the use of soft-disclosure interventions. When we speak of "soft" and "hard," we are referring to the function of the speech and not the form or content of the speech. For instance, not all apparently soft statements actually soften the emotional reaction of a partner. Imagine a couple whose distress is in response to the wife's depression. If a therapist were to try to get the wife to make a soft disclosure, such as "Sometimes I just feel so sad, like I'm just not good enough," her statement might move the therapist, but it might have the opposite effect on a partner, who may have heard many of these self-deprecating remarks before. Such a statement could simply be a further example of their pattern of neglected, depressed wife and overburdened, irate husband. However, if the therapist were to explore the husband's reaction without blame for his unsympathetic response, the husband might reveal that he hears those statements as messages that he has to take care of her and everything else in the household, and there is no one there for him. Disclosure of his emotion in this case might lead to a different, more meaningful and empathic discussion, wherein the wife feels for the first time that she is needed by him and comes to his emotional aid.

Therapists must therefore be aware and forewarned not to fall into a trap of accepting statements that appear "soft" as the type of disclosure necessary to actually soften a particular couple. Frequently therapists can be lulled into feeling that they have hit on something good when a speaker begins to cry; however, they must always remember that what is gold in the eyes of the therapist may be tin in the eyes of the other partner. It is essential for therapists to explore the emotional reactions of each partner, knowing there are good reasons for even seemingly unsympathetic reactions, and to rely on functional analytic skills along with the basic formulation for guidance in selecting the most salient areas to promote soft disclosure.

Unified Detachment

In unified detachment, we promote an analytic discussion of partners' struggles, helping them develop emotional distance from their conflicts by encouraging an intellectual analysis of those conflicts. Like empathic joining, unified detachment aims to help members of a couple talk about their problems without accusation and blame; however, unified detachment emphasizes the use of detached and descriptive discussions rather than emotionally laden discussions. Thus, when using unified detachment interventions, the therapist works with the couple to understand their struggle as an "it" in which they both engage rather than a "you" who does something bad to them. The problem is reformulated as a common adversary that the partners must tackle together.

The therapist can promote unified detachment by continually referring back to the major theme in the partners' interactions, their pattern of interaction, and the mutual trap into which they both fall. For instance, when Ray and David initially tried to resolve conflict about Ray's "flirtatiousness" with other men at social gatherings, the discussions quickly deteriorated. Ray accused David of being "jealous, timid, prudish, and overcontrolling." David accused Ray of being "insensitive, rude, slutty, and shameless." The therapist has earlier defined a theme of "closeness–distance" for Ray and David. In essence, Ray, a fiercely independent man, thrives on doing things his own way. He likes time alone and had been raised as an only child. David, however, likes frequent interaction. He grew up with three siblings, has never lived entirely on his own, even in adulthood, and feels best when he is sharing time with others. Although the theme of closeness–distance is not readily apparent in the interaction about flirtatiousness, the therapist is able to make a connection, relating Ray's behavior as being consistent with his independence and need to have time to himself even when the couple is in public, and David's behavior to his desire for closeness with Ray and for a feeling of belonging. The therapist is then able to help David and Ray recognize that they share a dilemma they can seek to resolve together. This removes the element of blame and allows them to look at the problem in a more detached manner.

Another way to promote unified detachment is to frame partners' differences and sensitivities as resulting from their different family backgrounds, their different cultural and ethnic backgrounds, or even their different genders. If one was raised in an emotionally expressive family, while the other was raised in an emotionally reserved family, the reserved partner may find the emotional expressiveness of the other partner particularly difficult to understand or cope with, and vice versa. By bringing up their different backgrounds, the therapist may enable the couple to look at their differences as just differences, rather than deficiencies in one partner or the other.

Still another way that an IBCT therapist can promote unified detachment is by helping the couple articulate the pattern in a particular conflict, such as a negative incident on the Weekly Questionnaire. By encouraging partners to take an observer's perspective on the conflict, the therapist can have each identify triggers for emotional reactions, the escalating efforts to get the other to understand, the subsequent distance between partners as they "lick their wounds," and their perhaps unsuccessful efforts to bridge the gap between them. As the partners describe the pattern of interaction between them, they begin to see it in a less emotional, more detached, and more unified way. Sometimes IBCT therapists encourage partners to come up with a descriptive, perhaps even humorous name for their pattern as a way of achieving this goal of detachment. Obviously, the name should not demean either and be acceptable to both.

An IBCT therapist can also promote unified detachment by getting the partners to compare and contrast incidents that occur between them. For example, perhaps José was less disturbed by Maria's working last Sunday than he was the previous Sunday because they had spent such a close time together last Saturday night. If they both see how genuine closeness alleviates the distress of emotional distance, they may be able to better manage their needs for both.

Direct or Deliberate Change Strategies

In IBCT, we can distinguish between two broad types of change that couples want: (1) change in the emotional climate between the two and (2) change in particular behaviors important to one or the other. Sometimes couples struggle about the two, such as when one partner insists, "You should treat me nicer and then maybe I can do some of what you want" while the other insists, "How can I treat you nicer when you have resisted doing so many things that are important to me?" We don't enter on either side of that conflict by pressuring one to be nicer or the other to change particular behaviors. Instead, we start with empathic joining and unified detachment, exploring and validating the dilemmas that both partners are in ("I am too upset at your resistance to my requests to treat you nicely" and "I am too angry at the way you treat me to want to make any changes to please you"). As a result, partners may soften toward each other and the emotional climate may change somewhat, and partners may begin to change certain behaviors important to the other. Thus, sometimes empathic joining and unified detachment over a number of sessions can bring about both kinds of changes.

However, even when empathic joining and unified detachment bring about understanding and softening between partners, it may still leave them struggling with particular issues. Then we engage in direct or deliberate change strategies. When promoting change and working with couples who are broadly functional in everyday life, we assume they have a repertoire of communication and problem-solving skills and have used them successfully in many areas of their life. Therefore, we want to access their existing behavioral repertoires to bring about change and only secondarily attempt to teach new communication or problem-solving skills. Our assumption is that prompting or eliciting constructive behaviors already in a couple's repertoires will feel more natural to them, will lead to a sense of ownership of the changes, and will be more likely to maintain than teaching them new constructive behaviors not currently in their repertoire.

CATCH PARTNERS MAKING IMPROVEMENTS AND DEBRIEF THOSE EFFORTS

Unless partners have given up completely on their relationship, they will make efforts to improve it by doing things for the partner or by being friendlier to the partner. In almost every session, we review the most positive interaction that has occurred between partners and thus try to capture, debrief, and reinforce those efforts by each, even if the effort was misread by the other or met with initial distrust. When those positive events involve the couple handling one of their difficult issues in a better way, we debrief those interactions in detail, highlighting what each partner was able to do to make a normally problematic situation go better. Thus, we "catch them doing good" and attempt to reinforce their natural efforts to resolve some of their problems.

HAVE PARTNERS TROUBLESHOOT PROBLEMS

If empathic joining and unified detachment have brought partners into a collaborative place with each other, we can have them troubleshoot difficult points in their usual pattern of interaction or aspects of the underlying problem by asking them what they think they could do to help. For example, Mark and Dana have a hard time recovering from their arguments because Mark wants to "let it be and move on," while Dana wants to review it and ideally get an apology from Mark. Their struggle over how to recover often becomes more intense than the original argument that necessitated the recovery. Knowing that Mark and Dana are in a more collaborative place and really understand their mutual dilemma, the IBCT therapist might ask what they think would help them get out of this bind. They might discuss various alternatives, and even if they don't settle and agree on one, the discussion often eases their recovery struggle, so that Mark doesn't refuse to listen to Dana and push as much to move on and Dana doesn't press as much for unqualified apologies.

REPLAY INTERACTIONS THAT DIDN'T OR DON'T GO WELL

Another related change strategy is to have partners replay a difficult interaction in the therapy session but attempt to "make it go better." We do this in IBCT only after the couple has a good understanding of their pattern of interaction and are aware of the triggers for each other. We typically start with generic prompts such as "Try to do it better," because we seek the most improvement from the least intervention. That way, the improvement is more likely to generalize outside the therapy session and maintain, rather than if we gave maximum coaching and had maximum control. Of course, a couple may not do better with general instructions such as "Do it better," and we may have to provide more detailed prompts or coaching. For example, we might ask Mark and Dana to replay their recovery from a recent conflict but "try to do it better." If they still got stuck, we might ask both to voice their emotional struggle at the moment, which might lead Mark to say, "I know you want to talk about it but I think you are just going to tell me all the wrong things I did" and Dana to say, "When I am upset but can't discuss it with you, I feel shut out and get even more upset." But those revelations might lead them to a more meaningful discussion and recovery.

TOLERANCE BUILDING

Strategies of tolerance building attempt to reduce a partner's emotional reactivity to triggering behaviors in the other that are not egregious or dangerous, but do so in a direct, focused way. Thus, they are both acceptance-focused and change-focused strategies. As part of tolerance building, we sometimes engage partners in a discussion of the impact and consequence of behaviors they experience as negative, being alert to ways that one partner's negative behavior may have positive aspects for the other, currently or in the past. For example, an emotionally labile person and an emotionally stable person may have been attracted to each other in part because of those differences, yet now they often find them distressing. Highlighting these aspects may help partners see the benefits of behaviors that are otherwise experienced as distressing. However, the therapist relies on an understanding of the function of the behavior rather than on concocting a "silver lining" and simply doing a positive reframing of a negative behavior.

We may attempt to increase tolerance by having partners practice negative behavior in the therapy session, both to desensitize each partner to the other's negative behavior and to sensitize the offending partner to the impact of the behavior on the other. These two objectives apply also to faking the negative behavior at home, which we address next. For example, if Daren and Meg get locked in an emotionally distressing pattern in which he evaluates her parenting negatively and she dismisses his comments with a wave of the hand, we might ask them to play that out in the session. In so doing, they might laugh at their attempts to deliberately do something that normally they do spontaneously or they might trigger each other somewhat, although less dramatically than they normally do. In these cases, the exercise could be followed with unified detachment in the first case and empathic joining in the second. The entire process might increase tolerance to these behaviors.

Sometimes we follow this intervention with a request to partners to engage in these behaviors during the week at home, but only when they do not feel naturally compelled to do so. For example, we might ask Daren to evaluate Meg's parenting when he is really not into it and Meg to dismiss his comments with a wave of her hand when she really doesn't feel it. After engaging in the faked behavior, they are asked to reveal the fake, then debrief the interaction. Partners should tell each other what they observed during the interaction, and the partner who has faked the behavior should, in particular, explain what the impact of the faked behavior is.

Partners frequently report that although they have difficulty actually completing this kind of homework, being given the assignment makes them more aware of their behavior. This increased awareness itself serves to decrease the problematic behaviors. Moreover, because the partners choose moments during which they engage in negative behaviors, these behaviors are brought under their voluntary control. This experience helps partners to realize that they have choices about how they want to respond to or interact with one another. Finally, because partners expect to be "faked out," they tend to react less severely to the negative behaviors that formerly annoyed them. In essence, each partner becomes less sensitized to the negative behavior through repeated exposure; as a result, tolerance is promoted.

Both of the last two strategies, practicing negative behavior in the session and faking negative behavior at home, are not usually employed until a couple has achieved some unified detachment from the problem. The partners need to first see how their behaviors maintain or escalate rather than ameliorate their difficulties, even though they still may get caught up in those dysfunctional behaviors at times. The therapist has most influence when the couple is practicing negative behaviors in the session and can intervene if the practice becomes the reality. Thus, the therapist should not instruct the couple to fake the behaviors at home until they have practiced them in the session to good effect.

A final method of promoting tolerance is helping partners engage in self-care. There are times when the other is unable to be there for them, and if they can tap other resources within themselves or their social environment, they will be better off as will the relationship. For example, it might be beneficial at times for one partner to debrief emotionally distressing experiences with a friend rather than the partner. Self-care interventions should be proposed cautiously because we don't want to imply that the partner has no role or responsibility in assisting the other.

TRADITIONAL CHANGE TECHNIQUES

We can employ traditional change techniques in IBCT, such as behavior exchange strategies, and communication and problem-solving training. However, they are not our first line of intervention because, as we explained earlier, we would rather bring to bear partners' own repertoires of behavior rather than teach them new behavior. These traditional techniques are discussed extensively elsewhere (e.g., see Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), so we don't discuss them further here.

Sequencing Guidelines

We typically begin treatment with empathic joining and unified detachment interventions. Often these acceptance-based interventions, buttressed by the tolerance interventions, may produce as a by-product the very changes that the partners entered therapy requesting. Most partners do care about each other and wish to please each other, so when therapy is able to end the struggle for change—the cycle of "persist and resist" that is common in distressed couples—partners may accommodate each other. In these cases, the need for change-oriented techniques may be obviated.

With other couples, the acceptance and tolerance work creates the collaborative spirit required for change-oriented work, and therapy naturally progresses toward problem solving. In all cases, change techniques can also be interspersed throughout the therapy, though therapists should be quick to return to acceptance interventions if the emphasis on change appears to exacerbate conflict. IBCT therapists should never try to "force-feed" change strategies to couples at any point in the process of therapy.

Although we recommend these sequencing guidelines for therapists, they are only "rules of thumb." In some cases, for instance, both partners may enter treatment with a strong collaborative set, and it may be appropriate to begin with change-oriented interventions. In general, the intervention chosen by a therapist at any time is highly dependent on the context in which a certain interaction is occurring, and fixed rules are difficult to delineate.

MECHANISMS OF CHANGE

IBCT suggests that improvements in relationship satisfaction and stability come about through changes in behavior and changes in the emotional reactivity (acceptance) to behavior. Using data from a large clinical trial of IBCT and TBCT (described further below), Doss, Thum, Sevier, Atkins, and Christensen (2005) conducted a detailed examination of the mechanisms of change. They found that changes in target behaviors were associated with improvements in satisfaction early in treatment, but that changes in acceptance of those target behaviors were associated with improvements in satisfaction later in treatment. TBCT generated larger changes in behavior than IBCT early, but not later, in treatment. However, IBCT generated larger changes in acceptance throughout treatment. Thus, the study provided important validation for the mechanisms of change in both IBCT and TBCT.

There is some evidence that couples in IBCT become more emotionally expressive and engage in more nonblaming, descriptive discussion. One early study documented that couples treated with TBCT and IBCT demonstrated significant differences in the types of interactional changes observed over the course of treatment (Cordova, Jacobson, & Christensen, 1998). For example, observations of early, middle, and late therapy sessions indicated that IBCT couples expressed more "soft" emotions and more nonblaming descriptions of problems during late stages of therapy than did TBCT couples.

A more recent and extensive look at positive and negative client behaviors during early, middle, and later sessions of TBCT and IBCT (Sevier, Atkins, Doss, & Christensen, 2015) found a "boost–drop" pattern in constructive behaviors during TBCT. Couples showed an early increase in positive behavior and decrease in negative behavior, probably because of TBCT's initial focus on positive behavioral exchange and its emphasis on communication and problem-solving training but using these skills only on minor problems initially. Later in therapy, there was a decrease in positive behavior and increase in negative behavior, presumably because long-standing issues were finally addressed. In contrast, IBCT showed a "drop–boost" pattern of constructive behavior. Couples showed an early increase in negative behavior and decrease in positive behavior, presumably because IBCT focuses on major issues of concern to the couple from the very beginning. Later in therapy, IBCT couples showed an increase in positive behavior and decrease in negative behavior, presumably as they made some progress on their major issues. It is important to note that this drop–boost pattern in IBCT was not associated with greater dropouts. If anything, IBCT had fewer dropouts than TBCT.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

IBCT was developed to improve established but distressed romantic relationships of married or cohabitating couples, including both different-sex and same-sex couples. It is not a treatment to assist partners in mate selection or a treatment to facilitate separation and divorce. It has been used successfully with ethnically and racially diverse couples from different economic backgrounds.

Couples in which there is moderate to severe violence, such as violence that has led to injury, are inappropriate for IBCT. The emotional intensity that is sometimes generated in couple therapy could lead to a violent episode in these couples. Also, couples in whom there is physical intimidation to such an extent that one partner may be afraid to express him- or herself for fear of physical reprisal are inappropriate for IBCT, since open expression by both partners is a goal of the therapy. Furthermore, the dyadic perspective of IBCT may not be appropriate for couples in which there is violence or intimidation.

Certain psychiatric disorders, such as schizophrenia, bipolar disorders, or substance use disorders, are contraindicated for IBCT, since they may interfere with treatment and/or require treatment first. Certain personality disorders, such as borderline, schizotypal, or antisocial personality, may similarly interfere with treatment or need attention first. IBCT can proceed with these couples as long as individual treatment prior to or concurrent with IBCT has brought these disorders under sufficient control for the client to participate effectively in couple therapy.

In order to extend the reach of IBCT to couples who cannot afford therapy, have transportation or child care challenges in getting to therapy, or simply are uncomfortable going to a therapist, we developed self-help books (Christensen, Doss, et al., 2014; Christensen & Jacobson, 2000) and the OurRelationship program, a digital, self-help adaptation of IBCT (*www.ourrelationship.com*). We focus here on the OurRelationship program, as it has been the focus of extensive research, documented below.

The OurRelationship program comprises about 7–8 hours of self-directed content and is typically accompanied by four 20-minute calls with a coach. It has three phases designed to help couples identify one or two relationship issues to focus on during the program, develop a DEEP understanding of those issues, and identify potential solutions to those issues. Each partner completes most of the self-directed content separately, but they come together at key moments in the program to share what they have generated in their individual sections and make key decisions. The program facilitates these conversations by displaying each partner's responses on the screen and using structured speaker–listener and problem-solving conversation formats. The OurRelationship program is described in detail in Chapter 30, in this volume, by Doss, Knopp, Wrape, and Morland. Additionally, more information on how therapists can integrate the program into a course of couple therapy or individual therapy can be found in our treatment manual (Christensen et al., 2020) and at *www.ourrelationship.com/therapists*.

As described below, the OurRelationship program has been shown to improve multiple domains of relationship and individual functioning. Notably, these gains have been observed in nationwide samples of different-sex distressed couples (Doss et al., 2016) as well as large samples of low-income couples (Doss, Knopp, et al., 2020), and these gains maintain over at least a 1-year follow-up (Doss et al., 2019; Roddy, Knopp, Georgia Salivar, & Doss, 2021). The OurRelationship program's effects on relationship functioning have been shown to be invariant across gender (Doss et al., 2016; Doss, Knopp, et al., 2020), race, ethnicity, education, income, age, marital status, or parenting status (Georgia Salivar, Roddy, Nowlan, & Doss, 2018; Rothman, Roddy, & Doss, 2021). It has been shown to be effective for couples with moderate-to-severe levels of intimate partner violence (up to and including "punching"; the program also has significant effects on relationship functioning for same-sex couples (Hatch et al., 2021) and active duty/veteran couples (Georgia Salivar, Knopp, Roddy, Morland, & Doss, 2020)—although perhaps with smaller effects than for other populations.

Empirical Support

Three randomized clinical trials of in-person IBCT have been conducted. Wimberly (1998) randomly assigned eight couples to a group format of IBCT and nine couples to a wait-list control group and found superior results for the IBCT couples. In an early, small-scale clinical trial (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000), 21 couples were randomly assigned to TBCT or IBCT; results demonstrated that both husbands and wives receiving IBCT reported greater increases in marital satisfaction than those receiving TBCT at the end of treatment. Moreover, with use of clinical significance criteria, results further suggested that a greater proportion of couples treated with IBCT improved or recovered (80%) compared to couples treated with TBCT (64%).

In a large-scale clinical trial conducted at UCLA and the University of Washington, 134 seriously and chronically distressed couples were randomly assigned to IBCT or TBCT. Treatment comprised a maximum of 26 sessions, typically over a period of 8–9 months. Couples participated in extensive assessments before, during, and after treatment, and for 5 years following treatment. Couples in both conditions showed substantial gains during treatment (Christensen et al., 2004), which were largely maintained over the 2-year follow-up period; 69% of IBCT couples and 60% of TBCT couples demonstrated clinically significant improvement at the 2-year follow-up, relative to their initial status (Christensen, Atkins, Yi, Baucom, & George, 2006). Gains were also apparent in observational data of problem-solving interactions (Baucom, Sevier, Eldridge, Doss, & Christensen, 2011; Sevier, Eldridge, Jones, Doss, & Christensen, 2008), as well as parenting and child behavior (Gattis, Simpson, & Christensen, 2008). At each 6-month follow-up point for the first 2 years following treatment termination, IBCT couples showed significantly higher relationship satisfaction than did TBCT couples. However, over the next 3 years of follow-up, couples lost some of their gains, and outcomes for the two treatments converged, so that at the 5-year follow-up, only 50% of IBCT couples and 46% of TBCT couples showed clinically significant improvement, while 26% of IBCT couples and 28% of TBCT couples were separated or divorced. However, there were still what are considered to be statistically large effect sizes for improvement in relationship satisfaction from pretreatment to the 5-year follow-up (Christensen et al., 2010).

Based on these data, in 2010, the U.S. Department of Veterans Affairs (VA) adopted IBCT as one of its evidence-based family treatments. In the 10 years since that time, approximately 500 VA therapists have gone through an extensive training program in IBCT, consisting of a several-day workshop followed by 6– 8 months of weekly supervision of their work with couples. As part of this supervision, the therapist trainees audio-record at least 20 sessions of couple therapy and get feedback from their IBCT-trained supervisor. Over a thousand couples have been seen by these therapists during their training period, and many more couples have been seen since the therapists completed their training. Data collected from couples during the training period show that these IBCT therapists were able to bring about improved functioning in their couples even though the therapists were learning as they went along. Not surprisingly, the statistical effect sizes for these couples are somewhat smaller than the effect sizes seen in the clinical trial (Christensen & Glynn, 2019), even when couples have approximately the same number of sessions.

As of this writing, the effects of the OurRelationship program have been demonstrated in three randomized controlled trials involving over 1,400 couples—with additional studies currently underway. The effects of the program are detailed in Chapter 30, in this volume, by Doss and colleagues; therefore, we simply outline them here. The OurRelationship program improves at least five domains of functioning—relationship functioning, mental health, physical health, co-parenting/parenting, and child adjustment. Across multiple studies, the OurRelationship program has been shown to create medium-size effects (relative to a control group) on relationship satisfaction, communication conflict, breakup potential/relationship confidence, and emotional intimacy, as well as small-size effects on intimate partner violence. The program reduces depressive and anxious symptoms, stress, anger, and problematic alcohol use—especially for those who begin the program with difficulties in these domains. The program also improves couples' perceived health, insomnia, work functioning, and quality of life (Doss et al., 2016; Doss, Knopp, et al., 2020). Furthermore, these gains last for at least a year after the end of the program (Doss, Roddy, Nowlan, Rothman, & Christensen, 2019; Roddy et al., 2020). Compared to the control group, couples with children also report reductions in co-parenting conflict, as well as improvements in their children's externalizing and internalizing symptoms (Doss, Roddy, Llabre, Georgia Salivar, & Jensen-Doss, 2020).

CASE ILLUSTRATION

The following case illustrates a typical course of IBCT and some of its primary interventions. First, we describe the assessment phase, including the initial conjoint interview and the two individual interviews. Then we describe the feedback session, including the DEEP formulation for the couple. Finally, we describe some of the key incidents that arose during the intervention phase, showing how the therapist used three key strategies of IBCT to assist the couple: empathic joining, unified detachment, and tolerance building.

Information from the Initial Session

Hector and Alejandra, both 31 years old, an unmarried Latinx couple without children, currently live together. Both are college educated; Hector works as a reading specialist, while Alejandra teaches English as a second language at a community college. They sought therapy after having a long discussion about whether they had made the right decision to move in together and consider marriage after having had an "on again, off again" relationship for the previous 4 years. They hoped therapy could help them with their decision and with some ongoing problems of trust that were contributing to their doubts.

The two had met in college 8 years previously, when they developed a friendship within a tight-knit group of classmates. After college, they started a romantic relationship that ended 6 months later when Hector reconnected with a former girlfriend from college. Four months later, after the former girlfriend moved across the country for graduate school, Hector and Alejandra again got together, becoming "friends with benefits." Later, their best friends, a couple, Shawn and Maria, convinced them they were a good match for each other, and they agreed to become exclusive and were so for a year. However, they could not agree on whether to live together and remained living apart. Hector was ready to settle down but Alejandra questioned his maturity, concerned that he spent too much time at his favorite bar. Later Alejandra discovered that Hector was still in contact with his former girlfriend who was living across the country. By accident, she found a series of provocative photographs from his former girlfriend with solicitous and complimenting texts from Hector. Alejandra broke up their romantic relationship, telling Hector she wanted to just be friends "without benefits."

The two did remain friends, more distant than before and casually dating other people. However, their relationship once again became more serious after they had what they described as a "drunken night of passion" following a mutual friend's wedding reception, resulting in Alejandra becoming pregnant. Not wanting to be forced into a decision based on having a child, Alejandra decided, and Hector agreed, that she would terminate the pregnancy. This went against their Catholic upbringing and each experienced a sense of grief and guilt. Hector was very concerned about Alejandra's emotional health during that time, and she drew closer to him, as she thought he had "grown up" to be supportive and caring. Once again, Hector asked Alejandra to consider settling down with him, and they decided to move in together.

Their relationship felt "both good, and very rocky" to each of them. While neither of them practiced any particular religion, each had family with strongly held beliefs, so the abortion was a secret they carried together. Alejandra said that despite the fact that both had always believed that people should fully explore their sexuality and "live fully," this was the first time in her life and in their relationship that she "felt dirty." Hector tried to remain supportive, but he wanted to move on from the decision about the pregnancy, and he occasionally became upset when Alejandra wanted to talk about it. One very painful episode that convinced them to seek therapy occurred when they were invited to dinner by Shawn and Maria, who excitedly told them that Maria was pregnant with a baby boy. Alejandra expressed excitement to them but began weeping as soon as they were in the car returning home, and she told Hector she thought they would never really be able to be happy because of "what they did."

Information from the Individual Interviews

In their individual interviews, both Alejandra and Hector indicated that they were strongly committed to the relationship. Neither reported any history of violence in the relationship, nor did either report having an affair during the time they lived together. However, both worried about the other's fidelity. Alejandra worried that Hector might still be interested in his former girlfriend. Because they lived in the small city in which Alejandra grew up, Hector worried about all the men still around whom Alejandra used to know and date.

Both were raised in Catholic families, but Alejandra's parents were much more devout than Hector's. Her parents were strictly against abortion and thought living together before marriage was wrong. Although Catholic, Hector's parents were less adamant in their views in general, and in particular about abortion and premarital sex.

Hector complained that Alejandra would get stuck and couldn't move on. As examples, he talked about her continuing guilt and sadness about the abortion, her refusal to reveal it to her parents or even reveal to her parents that they lived together, her continuing lack of trust in him because of his old girlfriend, and her difficulty deciding on marriage. For her part, Alejandra complained that Hector would not listen to her when she was down or sad about the abortion or talk to her about her concerns but would instead become angry or distant. She sometimes felt abandoned when she needed him the most.

Despite these problems, both described a strong attraction to each other. Alejandra revealed that she had never really fallen in love with anyone she dated, apart from Hector, or, she said, "at least not in the same way." She said that the intensity of their relationship was partly due to how good a friend he was, their strong passion, and their shared interests and values. She said her only real regret was "letting her guard down" the night that she had become pregnant, and she thought that dealing with the outcome of that night had led to doubts about whether she had become too similar to Hector.

The Feedback Session

The therapist identified two broad themes that captured the issues with which Hector and Alejandra struggled: trust in the other and something that could be called "the thinker and the leaper," with Alejandra being more emotional and thoughtful about major issues and decisions, and Hector more willing to move on and "throw caution to the wind." He was ready to move on from the abortion, reveal their living together and perhaps the abortion to her parents, and get married, despite their ongoing issues. Alejandra was more emotional about the abortion and more reticent about those major steps.

A DEEP analysis of the trust issue revealed important differences between the two in how much contact to have with old friends with whom one of them had had a physical or romantic relationship. Hector thought that it was up to each of them to decide and wanted to continue having contact with his old girlfriend. Alejandra thought that a firm boundary around previous lovers was the best way forward. Both had some emotional sensitivities around trust. Hector was troubled by all the former lovers that Alexandra had who were still around and with whom they had contact. Alejandra was particularly stuck on Hector's continued friendship with his former girlfriend who lived across the country. Because both experimented sexually with other relationships in their past even while they had a relationship with each other, both wondered about the other's ongoing sexual interest. They saw the irony in the fact that a sexual philosophy on which they both agreed during their earlier years made them anxious about one another's ongoing faithfulness. External stressors often reduced Alejandra's sexual interest but increased Hector's, leading him to question her interest in him. A common pattern of interaction around trust came up when they would go out to eat or to a bar and a male friend of hers would wave or stop to say "hello." Hector would often ask, "Did you do him?" He often claimed it was a joke, but he actually wondered and worried about an old lover, while she was annoyed by what she felt was inappropriate curiosity and a subtle criticism of her. They would end up in arguments, both of them growing quiet and disengaged. Another pattern occurred when he was out with friends and she would text or call him frequently to "try to connect," which made him feel like she was just checking up on him.

A DEEP analysis of the second theme highlighted the differences between Alejandra, the emotional thinker, and Hector, the leaper. They could not agree on how much to tell family and friends about their lives, and they often struggled when Alejandra was emotionally upset, such as with the abortion. Hector thought that Alejandra had come to view them both as broken people, or even as bad people because of the abortion, and he held strong beliefs that people were never bad even though they occasionally did bad things. Alejandra often felt emotionally unsupported or abandoned by Hector when she was upset. Hector was annoyed that she would not "move on," but he also felt helpless when she was upset and there was nothing he could do to help her get over it. When events triggered her emotional arousal, as in the incident with their friend's pregnancy, their struggle was particularly intense. They became trapped in a dysfunctional pattern of interaction in which Alejandra would become noticeably upset, Hector would become emotionally and often physically distant, and she would then feel alone in her sadness and become angry with him. He in turn would get angry at her for not "getting over it."

Active Intervention: Examples of IBCT Strategies

Although a variety of acceptance and change strategies were used with Alejandra and Hector, we illustrate empathic joining and unified detachment around a problem, which are conceptually separate interventions but are often used together, and tolerance building.

Empathic Joining and Unified Detachment around the Problem

At one point in therapy, Hector had asked Alejandra if she wanted to go shopping for rings, and if she wanted an engagement ring. Alejandra was surprised by this and thought that he was pushing ahead and ignoring their problems and her concerns. Hector felt like she had lied to him about being truly serious about the marriage.

HECTOR: I thought we were coming to therapy to shore things up and make sure we succeed in being married.

ALEJANDRA (*eyes averted*): I thought we weren't going to rush, that there was no reason.

HECTOR: I thought there wasn't anything so serious that we had to wait on the fun stuff, like rings. I also thought it might be a good distraction from the mixed feelings you have about Maria's baby.

ALEJANDRA: So, getting rings was a distraction? (*Sarcastically*) That makes me feel so much better, so close to you.

THERAPIST: (*to Alejandra*) You know, this sounds to me like a situation that is similar to others we have talked about in the past, when you have felt that Hector just didn't get you.

ALEJANDRA: That is how it feels. (*tearing up*) Like he just can't let me feel sad about this, about what we did.

THERAPIST: (*to Hector*) I suspect that you also feel sad and that it makes you feel even worse when you see Alejandra suffering.

HECTOR: I thought if she could get excited about getting married, look to the future, we'll have kids . . .

ALEJANDRA: Don't go there . . .

THERAPIST: Hold on a second, Alejandra. Hector, I wonder if you are trying to support and maybe even protect Alejandra in your own way.

HECTOR: I don't know about protect, but support, cheer. Sure.

THERAPIST: (*to Alejandra*) I want to make sure that you are really hearing what Hector is saying. Rather than invalidating your feelings he is trying to help you so that you aren't suffering as much?

ALEJANDRA: Yes, but I can do my suffering without needing to be cheered up. It seems like he just doesn't want to feel bad.

THERAPIST: (*to Hector*) So how do you respond to that? Can you see that Alejandra is capable of holding her own sadness and doesn't need you to take it away?

HECTOR: Yes, I see that, and she is right. I don't want to feel bad, but I am not trying to feel better at her expense. I really want to help not hurt.

Therapist: I think that you both do your fair share of suffering about this action you took, although you are in different places about it now. You also both are different people. Remember our earlier discussion of "the thinker and the leaper?" It is like, Alejandra, you can sit in the thought, deal with the feelings, kind of swim in them, if you will. Hector, you cope with problems by trying to solve them or moving beyond them. These are different styles, styles that you've had all the years you've been good friends and good lovers.

Alejandra: Well, I wish that when I am "swimming" as you say, Hector didn't make me feel like I was wallowing.

Hector: I would never accuse you of that. I just don't want a very hard thing we did to haunt us forever and to keep us from having all that we want together.

Alejandra: I may be haunted forever, and I can move forward. I just need to feel really secure, and we just aren't there yet. Soon, I hope, I mean that is why we are here. Can you just have a little patience and trust me?

Hector: Yes, as long as I know you are still with me.

Alejandra: I assure you, I am.

When using an empathic joining intervention, the therapist does not attempt to encourage the partners to resolve the conflict or to compromise with one another. The task of empathic joining is to help the partners explore their feelings and motivations about an issue in a way that allows them both to experience being heard, validated, and supported. In this example, both partners needed to feel that they were supported, not only that plans hadn't changed but also that there was room to take time to feel their feelings and remain hopeful about the future. This example also briefly illustrates unified detachment in that the therapist reminded them of their key differences, the thinker and the leaper, as a way to conceptualize their struggle without blame.

The therapist used another example of unified detachment that led to self-initiated change by the couple several sessions after the previous exchange. They wanted to discuss an argument they had had about getting a gift for Shawn and Maria's baby. Alejandra wanted to buy an expensive stroller, had spent time looking online, and was ready to purchase. Hector thought she was possibly overcompensating for not really being happy for them, and he wanted to get something much less expensive to save money for their own wedding down the road. As in many unified detachment interventions, the therapist used empathic joining to help soften the couple around the issue. The therapist then framed the problem as "Alejandra and Hector both want to do something nice for their friends, but don't agree on how to monetize it." When they were able to see the situation as both of them wanting to do something for their friends, without throwing aspersions at one another about "overcompensating" or "pushing to get married," they were able to compromise on the purchase without the therapist engaging in formal problem solving. Since Alejandra was looking at something for transporting the baby, Hector suggested they look for a wrap carrier for the baby. They agreed that was a nice idea and agreed on limiting the expense.

Tolerance

Trust continued to be a problem for Alejandra and Hector: He was troubled by her calling or texting him when he was out with friends; she was troubled by his inquiries about her possible past sexual contact with local men they encountered. Thus, the therapist decided that a tolerance exercise could help desensitize them to this pattern and alleviate some of the difficulty it caused.

After empathic joining and unified detachment had created understanding of the problem and reduction in mutual blame, the therapist suggested the following "faking negative behavior" exercise for them to try at home regarding these behaviors. Alejandra was instructed to call Hector and ask where he was or when he would be home during a time when she really wasn't worried. Since his distress was often indicated by a "minimalist" response—silence, grunting a "yes" or "no," sighing—she was to wait for that response, then tell him this was the therapy assignment. Then they were to talk about his reaction when they were both at home.

Hector was also given a "faking negative behavior" assignment. When they were out in public and met a man who seemed to know Alejandra but who did not arouse Hector's concern about her past behavior with the man, Hector would secretly whisper in her ear, "So, did you do him?" He would listen for her reaction, and when he sensed distress—raising her voice or getting silent—he would tell her this was the "faking homework" and they would discuss it later.

In their next session, they reported that they had done the homework but it didn't work because Alejandra laughed the two times Hector whispered the question, and Hector had guessed that her calls were part of the homework and responded with an outrageous comment like "I'm in the middle of a wild orgy right now. Can you call later?" They both said it turned out to be fun and not serious. This often happens with these interventions, making them an exercise in unified detachment—they laugh at the problem.

Case Summary

Hector and Alejandra completed 20 sessions of IBCT. At the termination of therapy, both stated that they were better able to understand each other's positions on a number of issues and felt less tension around those issues. The issues had not gone away: Alejandra still felt guilt about the abortion; Hector still found it difficult to allow her sadness rather than trying to fix it; and both had moments of distrust. Yet those issues did not jolt them as much, and they recovered from them more quickly. Objective measures of relationship satisfaction showed improvement by both, putting them in the range of nondistressed couples. Near the end of treatment, they surprised the therapist by bringing in little boxes containing their wedding rings, and while they hadn't decided on a date, they had agreed to take this step. In the year following termination of therapy, they sent the therapist a card that included a picture of them on their wedding day. Alejandra wrote that they were looking to buy a house: "We are making sure the house has room for a nursery someday." Clearly, this couple showed both immediate and continued benefits from IBCT.

CONCLUDING COMMENTS

IBCT is an evidence-based treatment for couples that integrates strategies for promoting acceptance in couples with the traditional behavioral strategies for promoting change. "Acceptance work" focuses on turning problems into vehicles for promoting intimacy and increasing couples' tolerance for what they see as each other's negative behavior. As couples let go of the struggle to change one another, change often occurs in response to natural contingencies.

The central conceptual framework that IBCT uses to understand a couple's core issues and to ameliorate those difficulties is the DEEP analysis. This acronym refers to natural Differences between partners around core issues, Emotional sensitivities that make the core issues particularly difficult for them to handle, External circumstances, especially stressors, that may exacerbate the differences and sensitivities, and the Pattern of interaction in which they engage to resolve the issues but which often create greater difficulties for them. IBCT attempts to promote emotional acceptance for the natural differences between partners and their emotional sensitivities, either emotional acceptance or change in the external circumstances depending on those circumstances, and change for their patterns of interaction, so they can handle their core issues in a more constructive way.

Several clinical trials have demonstrated the efficacy of IBCT. It has been adopted by the VA as one of their empirically supported treatments for couples; extensive efforts to train VA therapists in IBCT have continued since 2010, with positive results. IBCT has also been adapted into an online program, *www.ourrelationship.com*; recent nationwide clinical trials have demonstrated the effectiveness of that program across ethnic and income groups.

SUGGESTIONS FOR FURTHER STUDY

Books

Christensen, A., Doss, B. D., & Jacobson, N. S. (2014). *Reconcilable differences* (2nd ed.). New York: Guilford Press.

Christensen, A., Doss, B. D., & Jacobson, N. S. (2020). *Integrative behavioral couple therapy: A therapist's guide to creating acceptance and change*. New York: Norton.

Video and Online Resources

www.ourrelationship.com
http://ibct.psych.ucla.edu
www.apa.org/pubs/videos
https://www.youtube.com/watch?v=8jidWO_Q8Do&list=PLpRvfj_stbWFXnG7Hj2lJAhK8Ekyqwqqi&index=10

REFERENCES

Baucom, K. J. W., Sevier, M., Eldridge, K. A., Doss, B. D., & Christensen, A. (2011). Observed communication in couples two years after integrative and traditional behavioral couple therapy: Outcome and link with five-year follow-up. *Journal of Consulting and Clinical Psychology, 79,* 565–576.

Christensen, A. (2009). *Couple Questionnaire.*

Unpublished questionnaire. (To obtain this freely available measure, go to *http://ibct.psych.ucla.edu.*)

Christensen, A. (2010). *Weekly Questionnaire.* Unpublished questionnaire. To obtain this freely available measure, go to *http://ibct.psych.ucla.edu.*)

Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 78,* 225–235.

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology, 72,* 176–191.

Christensen, A., Atkins, D. C., Yi, J., Baucom, D. H., & George, W. H. (2006). Couple and individual adjustment for two years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 74,* 1180–1191.

Christensen, A., Doss, B. D., & Jacobson, N. S. (2014). *Reconcilable differences* (2nd ed.). New York: Guilford Press.

Christensen, A., Doss, B. D., & Jacobson, N. S. (2020). *Integrative behavioral couple therapy: A therapist's guide to creating acceptance and change.* New York: Norton.

Christensen, A., & Glynn, S. (2019). Integrative behavioral couple therapy. In B. H. Fiese (Editor-in-Chief) *APA handbook of contemporary family psychology: Vol. 3. Family therapy and training* (pp. 275–290). Washington, DC: American Psychological Association.

Christensen, A., & Jacobson, N. S. (2000). *Reconcilable differences.* New York: Guilford Press.

Christensen, A., Jacobson, N. S., & Babcock, J. C. (1995). Integrative behavioral couple therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 31–64). New York: Guilford Press.

Cordova, J. V. (2001). Acceptance in behavior therapy: Understanding the process of change. *Behavior Analyst, 24,* 213–226.

Cordova, J. V., Jacobson, N. S., & Christensen, A. (1998). Acceptance versus change interventions in behavioral couples therapy: Impact on couples' in-session communication. *Journal of Marriage and Family Counseling, 24,* 437–455.

Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based OurRelationship program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology, 84,* 285–296.

Doss, B. D., Knopp, K., Roddy, M. K., Rothman, K., Hatch, S. G., & Rhoades, G. K. (2020). Online programs improve relationship functioning for distressed low-income couples: Results from a nationwide randomized controlled trial. Journal of *Consulting and Clinical Psychology, 88,* 283–294.

Doss, B. D., Roddy, M. K., Llabre, M. M., Georgia Salivar, E., & Jensen-Doss, A. (2020), Improvements in coparenting conflict and child adjustment following an online program for relationship distress. *Family Psychology, 34,* 68–78.

Doss, B. D., Roddy, M. K., Nowlan, K. M., Rothman, K., & Christensen, A. (2019). Maintenance of gains in relationship and individual functioning following the online OurRelationship program. *Behavior Therapy, 50,* 73–86.

Doss, B. D., Thum, Y. M., Sevier, M., Atkins, D. C., & Christensen, A. (2005). Improving relationships: Mechanisms of change in couple therapy. *Journal of Consulting and Clinical Psychology, 73,* 624–633.

Funk, J. L. & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21,* 572–583.

Gattis, K. S., Simpson, L. E., & Christensen, A. (2008). What about the kids?: Parenting and child adjustment in the context of couple therapy. *Journal of Family Psychology, 22,* 833–842.

Georgia Salivar, E., Knopp, K., Roddy, M. K., Morland, L. A., & Doss, B. D. (2020). Effectiveness of online OurRelationship and ePREP programs for low-income military couples. *Journal of Consulting and Clinical Psychology, 88*(10), 899–906.

Georgia Salivar, E. J., Roddy, M. K., Nowlan, K. M., & Doss, B. D. (2018). Effectiveness of the OurRelationship program for underserved couples. *Couple and Family Psychology: Research and Practice, 7,* 212–226.

Hatch, S. G., Rothman, K., Roddy, M. K., Dominguez, R.M., Le, Y., & Doss, B. D. (2021). Heteronormative relationship education for same-gender couples. *Family Process, 60,* 119–133.

Heavey, C. L., Christensen, A., & Malamuth, N. M. (1995). The longitudinal impact of demand and withdrawal during marital conflict. *Journal of Consulting and Clinical Psychology, 63,* 797–801.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and change in couple therapy: A therapist's guide to transforming relationships.* New York: Norton.

Jacobson, N. S., Christensen, A., Prince, S. E., Cordova, J., & Eldridge, K. (2000). Integrative behavioral couple therapy: An acceptance-based, promising new treatment for couple discord. *Journal of Consulting and Clinical Psychology, 68,* 351–355.

O'Leary, K. D., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriage: The need for multimodal assessment. *Behavioral Assessment, 14,* 5–14.

Patterson, G. R., & Hops, H. (1972). Coercion, a game for two: Intervention techniques for marital conflict. In R. E. Ulrich & P. Mountjoy (Eds.), *The experimental analysis of social behavior* (pp. 424–440). New York: Appleton.

Roddy, M. K., Knopp, K., Georgia Salivar, E., & Doss, B. D. (2021). Maintenance of relationship and individual functioning gains following online relationship programs for low-income couples. *Family Process, 60,* 102–118.

Rothman, K., Roddy, M. K., & Doss, B. D. (2021). Moderating role of socioecological factors on web-based relationship interventions for lower income couples. *Journal of Family Psychology, 35*(8), 1192–1198.

Sevier, M., Atkins, D. H., Doss, B. D., & Christensen, A. (2015). Up and down or down and up?: The process of change in constructive couple behavior during traditional and integrative behavioral couple therapy. *Journal of Marital and Family Therapy, 41,* 113–127.

Sevier, M., Eldridge, K., Jones, J., Doss, B., & Christensen, A. (2008). Observed communication and associations with satisfaction during traditional and integrative behavioral couple therapy. *Behavior Therapy, 39,* 137–150.

Simpson, L. E., Atkins, D. C., Gattis, K. S., & Christensen, A. (2008). Low-level relationship aggression and couple therapy outcomes. *Journal of Family Psychology, 22,* 102–111.

Skinner, B. F. (1966). An operant analysis of problem solving. In B. Kleinmuntz (Ed.), *Problem solving: Research method teaching* (pp. 225–257). New York: Wiley.

Stith, S. M., McCollum, E. E., Amanor-Boadu, Y., & Smith, D. (2012). Systemic perspectives on intimate partner violence treatment. *Journal of Marital and Family Therapy, 38,* 220–240.

Wimberly, J. D. (1998). An outcome study of integrative couples therapy delivered in a group format. Doctoral dissertation, University of Montana. *Dissertation Abstracts International: B: The Sciences and Engineering, 58*(12), 6832B.

CHAPTER 5

Acceptance and Commitment Therapy for Couples

Erika Lawrence, Aaron Samuel Cohn, and Samuel H. Allen

In this chapter, we describe acceptance and commitment therapy (ACT) for the treatment of couple distress. A third-wave behavioral intervention developed by Steven Hayes and colleagues for the treatment of individuals (Hayes, 1993; Hayes, Barnes-Holmes, & Wilson, 2012), ACT has accumulated evidence as an effective treatment for a broad range of clinical issues, including depression and anxiety (Twohig & Levin, 2017), chronic pain (Feliu-Soler et al., 2018), and psychosis (Wakefield, Roebuck, & Boyden, 2018). Though it is an evidence-based approach rooted in radical behaviorism, ACT is ultimately experiential, and practitioners often bring great warmth and flexibility to sessions. True to its name, ACT fosters acceptance of pain, which is viewed as the inevitable consequence of humanity's most formidable tool, symbolic communication (Hayes, Strosahl, & Wilson, 2012). ACT is based on a unified model of psychological functioning known as *psychological flexibility*, or the capacity to pursue values-consistent action in the presence of painful thoughts and feelings. In contrast to psychological flexibility stands psychological inflexibility, or the effort to control painful thoughts and feelings despite negative consequences (e.g., staying in bed and missing work rather than facing the day burdened with depression). Rather than seeking to alleviate symptoms, ACT encourages clients to hold their pain lightly as they seek to live lives consistent with their own freely chosen values.

Over several decades, scholars have worked to establish a philosophically and scientifically rigorous foundation for their clinical insights. ACT is grounded in the pragmatist philosophy of *functional contextualism* (Hayes, 1993) and supported by a comprehensive research program, contextual behavioral science (CBS; Hayes et al., 2012). The basic science underlying ACT is a behavioral account of language called *relational frame theory* (RFT; Hayes, Barnes-Holmes, & Roche, 2001). The intellectual richness of this background lends ACT-related research great precision, scope, and depth. The hope behind such a bottom-up approach, however, is that the rigorous application of empirically tested principles may lead to novel applications that could not be arrived at by common sense alone (Hayes & Hayes, 1992). We present one such application in this chapter: ACT to target couple distress.

BACKGROUND

One of the foundational studies in the ACT tradition (Rosenfarb & Hayes, 1984) was designed as part of a critique of the then-burgeoning cognitive theories of clinical change. The results of the study, which compared different strategies for addressing children's fear of the dark, led CBS researchers to examine in greater detail the effects of rule-following on cognition and behavior (Hayes, Brownstein, Zettle, Rosenfarb, &

Korn, 1986). Rules and rule-following emerged as important ways in which language dominates behavior in individuals, and ACT emerged as a treatment designed to reduce the influence of rule-following and other language-mediated processes on the lives of individuals. However, an irony surfaced: Though it began, in part, with insights into the impact of a power-infused relationship dynamic on individual behavior, ACT has evolved primarily into a collection of strategies to increase psychological flexibility within individuals.

Clinicians who work with dyads must contend with a multilevel system. Any two individuals will possess different histories and current behavioral repertoires that will interact, giving rise to emergent properties within each system. Considerable evidence suggests that increasing psychological flexibility within partners can improve functioning at the relational level (e.g., Daks & Rogge, 2020). However, less is known about the specific processes whereby the flexibility within individuals influences interactions between and among other individuals to influence overall couple systems. This does not mean that relationship therapists must operate without a way to assess relationship functioning. Useful, evidence-based measures of relationship quality are available to examine relational phenomena at the dyadic level (see Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin). Regardless of the measure used, what is important is that the couple and the therapist agree on (1) what goals are desirable and (2) reliable ways to achieve these goals.

Previous efforts to adapt individual behavioral therapy to couples have underscored the importance of understanding phenomena at both the individual and dyadic levels of the couple system. The example of integrative behavioral couple therapy (IBCT; see Chapter 4, in this volume, by Christensen, Dimidjian, Martell, & Doss) reveals several contextual factors that limit the power of traditional behavior change techniques at the dyadic level. Such factors as differing levels of commitment, large age differences, differing levels of emotional engagement, different degrees of traditionality, and differing goals for the relationship are among the emergent properties that both supervene upon individuals' behavioral patterns and impact couple functioning, even if both partners already possess optimal psychological flexibility.

There have been only a few documented attempts to apply ACT as a model for couple therapy prior to this chapter. These models have proceeded on the assumption that increasing psychological flexibility in both partners is likely to result in improved relational health. Lev and McKay (2017) posited rigid adherence to interpersonal schemas as a primary determinant of relationship distress. Their proposed treatment comprises an eight-step, ACT-based protocol that addresses these schemas and the maladaptive coping behaviors engendered by those schemas. Dahl, Stewart, Martell, and Kaplan (2014) proposed links between psychological inflexibility and difficulties maintaining intimacy and equity. The authors reasoned that increased psychological flexibility in one partner would lead to improved relationships because both partners would be reinforced by the positive consequences that result from intimacy as a freely chosen value.

What has remained underdeveloped in some of the attempts to translate ACT for the treatment of romantic relationship distress (e.g., Dahl et al., 2014), as well as the literature on the associations between psychological inflexibility and romantic relationship distress (e.g., Daks & Rogge, 2020), is the understanding of phenomena occurring at the dyadic level. Though they present strong support for the link between improved individual characteristics (i.e., psychological inflexibility) and improved aspects of relationship functioning (i.e., relationship satisfaction), they overlook couple-level constraints that can exist—and persist—among even the most psychologically flexible partners. Herein we present a systemic ACT approach to the treatment of couple distress that includes a relational framework and what is known empirically about ACT processes and relational functioning, which will aid relational therapists in treating the couple and not merely the individual partners that comprise it.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

Couple Distress and Success: A Functional Contextualist View

A functional contextualist approach to couple therapy privileges the idiosyncratic goals of each couple and makes no theoretical assumptions about relational health (Gurman, 2015). Hence, therapists and couples must work together to co-construct what success in couple therapy will mean. In this respect, ACT for couples resembles narrative and solution-focused therapies, as well as its third-wave behavioral cousin, IBCT.

The growing field of process research in couple therapy suggests there also is a need for connecting interventions to outcomes, to understand what techniques or facets of our interventions account for change in target outcomes (Wadsworth & Markman, 2012). For the same reasons that ACT for individuals is built on psychological flexibility as a "unified model" of psychological health (Hayes, Strosahl, & Wilson, 2012), a progressive scientific approach to couple therapy requires a model of interactional processes that underlie successful relationships. Such a model, however, must also respect the vast diversity of relationships and avoid the pitfalls of earlier iterations of behavioral couple therapy that mistakenly assumed that couple dysfunction could be reduced to a finite number of characteristic behavioral patterns. Coalescing these two epistemologies, an apparent paradox emerges: Each couple has the right to define success for themselves and to know whether a therapeutic intervention is in fact likely to lead to the kinds of "success" that our therapeutic models can offer.

One proposed solution to this paradox involves integration (Gurman, 2015). Clinical wisdom and the professional literature are replete with frameworks, models, and theories that help couple therapists devise road maps for how couples may get from distressed states to satisfying and rewarding ones. At the same time, we acknowledge that an integrative approach is likely to be necessary to successfully address the heterogeneity among distressed couples' presenting problems and desired relationship goals. Thus, we argue that a progressive science of couple intervention requires at least provisional unification via an adequately comprehensive account of relationship quality.

If increasing psychological flexibility in individuals were sufficient to resolve relationship problems, ACT couple therapy would have no reason to exist. ACT therapists could be confident that their work to increase psychological flexibility and reduce experiential avoidance among their individual clients would redound to the benefit of their clients' most important relationships. However, to the extent that relationships are greater than the sum of their parts, individual functioning must be distinguished from relational functioning. One compelling argument for working with a couple comes from the goal-oriented nature of functional contextualism itself (Hayes, 1993). If an individual's goal is to improve the relationship, then the therapist can only help the client achieve the goal through creating the conditions that are likely to lead to change in the relationship; therefore, the relationship itself must be the unit of analysis. If a therapist's knowledge of a couple is limited to just one member, it is inadequate. ACT therapists who hope to help partners improve their couple relationships must be willing to involve both members of the couple in treatment and to effect change on the dyadic level.

Even though success in ACT couple therapy is defined as healthy functioning at the dyadic level, individual psychological flexibility within both partners is an important ingredient of workable relational functioning. The literature on psychological flexibility suggests that relationship quality is likely mediated by cognitions (i.e., beliefs and attitudes) within each partner about the other partner (e.g., "She is a demanding woman," "He is an insensitive man") (Hayes et al., 2001). These cognitions can also be shared by both partners (e.g., "We're at our best as a couple when we're having fun together and drinking"). At the level of the individual, psychological inflexibility can be problematic and lead to values-inconsistent behavior that is damaging to the relationship. For example, a husband who is quick to interpret his wife's complaints as hostile and to respond with defensiveness is likely to miss evidence of the validity of her complaint, signs of emotional vulnerability that may underlie any outward hostility in his wife, and his own physiological responses that may reveal fear or vulnerability within himself. However, although intervening with individual characteristics (i.e., psychological inflexibility, experiential avoidance) will likely influence certain relational outcomes, such interventions may not comprehensively address the relational distress that exists within two individual partners. In other words, an ACT approach for individuals does not, and should not, amount to an ACT approach for couples.

Couple Functioning Viewed from a Multidimensional, Relational Framework

We suggest conceptualizing the goals of ACT couple therapy by embedding these within a comprehensive framework of romantic relationship functioning such as the quality of relationship domains framework (QRDF; Lawrence, Brock, Barry, Langer, & Bunde, 2009; Lawrence et al., 2011). Within the QRDF, domains of couple functioning are conceptualized as multidimensional, dyadic, dynamic processes that are related yet distinct facets of the higher-order construct of couple relationship quality. The five domains of couple functioning have been identified at the relational level: quality of conflict management and conflict recovery interactions; interpartner support transactions; quality of emotional closeness, trust, and intimacy; quality of the sexual relationship; and respect, power, and control. These dimensions represent emergent properties of dyadic relationships that are, in principle and empirically, independent of the individual behaviors that give rise to them. One advantage of the QRDF is that it allows the therapist to cast an adequately wide net when assessing couple functioning and identifying relational treatment targets. When one or more of the QRDF dimensions emerges as a source of relational distress, the therapist can form hypotheses about relationship strengths, as well as the specific role that psychological inflexibility plays in the maintenance of the distress. Here, we summarize the phenomena captured in each of these domains of couple functioning, as well as prototypical descriptions of low versus high functioning within each domain.

Conflict Management and Recovery

Interactions pertaining to conflict comprise three facets: the sequence of behaviors, feeling and thoughts that occur during a conflict, and the process through which a couple recovers from a conflict. Distressed couples often present with high levels of conflict and limited capacity to deescalate and return to baseline. They often experience intense aversive emotion during arguments, negative partner attributions, and destructive behavioral patterns such as negative escalation, negative reciprocity, demand–withdraw patterns, mutual disengagement/avoidance, and even psychological and physical aggression. Moreover, distressed couples tend to either avoid any attempts to actively engage in conflict recovery processes or struggle to recover from conflicts in a healthy, productive way. Couples who function successfully in this domain can tolerate the affect that emerges with conflict, engage in more constructive behavioral patterns, and make more positive partner attributions. They are more likely to recognize and acknowledge their own contributions to the conflict and even feel closer after employing recovery strategies.

Interpartner Support

Interpartner support transactions occur between partners when one partner desires support from the other in the form of tangible help, information, or emotional soothing at times of heightened stress. Among couples with poor functioning in this domain, partners seeking support may not ask for what they need or even recognize what they want in the moment, yet will become frustrated or despondent when they do not receive the type of support they want. Moreover, the support provider will often provide a type of support that does not match the support desired by the recipient. Couples who have high functioning in this domain are able to engage in multistep dyadic dynamic interactions that lead to a match between the support desired and provided, that foster positive individual feelings for both partners, and that provide a valuable buffer against the vicissitudes of life.

Emotional Closeness, Trust, and Intimacy

This domain captures the quality of a couple's emotional closeness, warmth, interdependence, trust in each other and in the relationship, ability to be emotionally vulnerable with each other, and comfort expressing love and affection. Couples with poor functioning in this domain often feel little warmth or trust. They may have lost all or some of the fun and friendship with which they started. Attempts to self-disclose may be rare or punished by the partner. Sensitive topics that evoke emotional vulnerability may be avoided. Physical and verbal affection may be scarce. Couples who function successfully in this domain often show copious warmth, comforting, lightheartedness, and openness. It is important to note that the specific behaviors that embody these qualities can vary widely across cultures.

Quality of the Sexual Relationship

This domain captures not only the frequency and satisfaction of a couple's sexual activity but also the quality of sensual or physical affection, their comfort with communicating with each other about sex, and the impact of any sexual difficulties on their sex life. When a couple functions poorly in this domain, partners may disagree sharply about how often they would like to have sexual encounters. They may be deeply uncomfortable discussing sex in or out of the bedroom. Couples who function successfully in this domain are often able to ask each other for what they want in sexual encounters. If aversive emotions such as shame or guilt emerge in association with sex, they can often respond with compassion and acceptance.

Respect, Power, and Control

Functioning in this domain captures a couple's ability to respect and accept each other, as well as how well they balance issues of power and control. Couples who function poorly in this domain are often replete with coercive control. Partners may belittle each other's hobbies, interests, and careers, and try to keep each other from spending time with friends and family. Couples who functioning successfully in this domain treat one another as competent and independent adults. They tend to treat each other with respect, even when they disagree. Decision making is usually balanced, and partners are free to actualize their generative potential as human beings.

THE PRACTICE OF ACT COUPLE THERAPY

In this section we first present the six key processes of ACT as they apply to couple therapy. We then present specific dyadic strategies used in ACT couple therapy.

The Six ACT Processes and Mechanisms of Change

In ACT couple therapy, the six processes represent the mechanisms of change that lead to change in couples. The six targeted processes involve shifting: (1) experiential avoidance to acceptance, (2) cognitive fusion to defusion, (3) a lack of values clarity to contact with values, (4) inaction to committed action, (5) lack of contact with the present moment to present moment awareness, and (6) self as content to self as context. ACT couple therapists target each of these processes in service of creating greater psychological flexibility and a fuller, more mutually rewarding relationship. Here we provide a brief explanation of each of the processes and how they are relevant to ACT couple therapy.

Moving from Experiential Avoidance to Experiential Acceptance

People often try to reduce or eliminate unwanted or distressing internal experiences such as feelings, memories, or urges. Though natural and at times adaptive, this becomes problematic when we spend an excessive amount of time, attention, or energy trying to control these unwanted experiences. Moreover, there may be consequences to our efforts to control them (e.g., excessive drinking to avoid thinking about relationship problems or painful memories) that lead to increased suffering (e.g., relationship conflict, legal problems, missed work due to drinking). As ACT couple therapists, we believe that persons cannot control their automatic thoughts and feelings; they can only control how they relate to or respond to them. The goal in ACT couple therapy is to help partners be willing to experience uncomfortable internal experiences, to accept their presence rather than trying to control them, so that they may spend their time, energy, and attention in more fulfilling ways.

Moving from Cognitive Fusion to Cognitive Defusion

Everyone has thoughts that are upsetting or distressing. However, there are times when we may become fused with or stuck on some of these thoughts. We may feel intense emotions when these thoughts arise, or we may believe that our thoughts are reality or literal truths instead of simply recognizing them as thoughts generated by our minds. Getting fused with or stuck on thoughts limits the range of behaviors partners consider in response to a situation such as relationship conflict. Getting fused may also cause partners to remain "in their heads" rather than being present in the moment with their partner. As ACT couple therapists, we help couples notice their thoughts as thoughts rather than as literal truths or facts and introduce a variety of strategies designed to help them defuse or unhook from these thoughts. For example, a couple may be fused with the thought: "Because of our traumatic childhoods, we are damaged people incapable of having a healthy relationship." The ACT couple therapist could target the weight of the term "damaged" for this couple, have them repeat the word over and over for a full minute, until it changes from being a word that brings up strong emotions to a series of nonsense sounds, thereby helping the couple unhook or defuse from the word. Alternatively, the therapist might use a visual technique such as *Leaves on a Stream*, a guided meditation in which the couple imagines sitting by a stream with leaves slowly floating down it. Then they are asked to notice each thought they have, put each on a leaf one at a time, and watch them float down the stream. Across these techniques, the goal is to help couples practice noticing their thoughts as thoughts instead of simply having them or reacting to them.

Moving from a Lack of Clarity of Values to Clarification of Values

Distressed couples tend to be so focused on their current problems that they neglect to think about their relationship as a whole or about what they want their relationship to be like. Still others have never stopped to consider or identify their relationship values, let alone to determine whether both partners share the same relationship values. ACT couple therapists introduce a range of strategies to help couples identify and talk about their relationship values, and to help them use those values to guide the choices they make in the relationship, rather than allowing their thoughts and feelings to guide them in the moment. One strategy is to give partners a set of cards with different possible relationship values written on them and ask them to sort the cards into three piles: not important to me, somewhat important to me, and very important to me. The ACT couple therapist then asks the partners to choose their five top values from their very important to me list. Finally, partners are encouraged to share their top five relationship value with each other and discuss them. Another way to help couples identify their relationship values, particularly if this is not something they have thought about previously, is by asking them to imagine celebrating their anniversary 20 years from now and have them write down what they want those closest to them to say about their relationship at that anniversary party. Their written answers form the basis for a discussion of their relationship values.

Moving from Inaction or Unworkable Action to Committed Action

Partners often believe that their actions are driven by their thoughts or feelings (e.g., "Once I get angry, I'm on autopilot" or "Whenever she says that, I go from 0 to 100"). ACT couple therapists help couples learn to identify and commit to intentional actions each day that are consistent with their own relationship values; that is, couples can act nonconstructively in response to their uncomfortable thoughts and feelings, or they can act in ways that are in service of the relationship they want.

Moving from the Conceptualized Past or Future into the Observable Present Moment

Many people find themselves focusing on the past or worrying about the future instead of being fully present in the moment. ACT couple therapists help partners notice when they are not fully present. They introduce a variety of techniques to help partners bring themselves back into the present moment so they may connect with each other as the interaction is happening rather than responding based on a narrative of the past or a worry about the future. One strategy commonly used is to ask couples to close their eyes and simply focus on their breathing. The goal is to focus on their bodies rather than trying to change their breathing. Another technique is to ask couples to close their eyes and focus on what they notice with each of their five senses, one at a time. In both examples, the ACT couple therapist is attempting to move partners from focusing on their internal experiences to being present in the moment with each other.

Moving from Self as Content to Self as Context

People often find themselves caught up in whatever is happening in the moment, or in their internal experiences of what is happening in the moment. ACT couple therapists help partners learn to step back and notice everything that is happening: what is happening in the room, what is happening internally (i.e., their thoughts, feelings, and bodily sensations), what matters to them, and what choices they can make in the present situation. Learning to observe themselves in the moment is one way to help couples learn to pause and make more adaptive choices before responding to each other.

Beginning ACT therapists often seek to learn the correct way to choose ACT processes in session or the correct order in which to target these processes in therapy. One of the core tenets of ACT, which applies to ACT couple therapy as well, is that the one thing the therapist can do wrong is to get stuck in a process. The therapist needs to be flexible and willing to move among the six processes as relevant within and across sessions.

Additional Dyadic Techniques Employed in ACT Couple Therapy

ACT for couples is highly flexible and responsive to the idiosyncratic needs and desires of each couple. Although not time-limited, ACT for couples is goal-directed, and it ends when goals have been successfully achieved. It is a series of conversations guided by four prioritized components: co-construction of goals, co-construction of problems, targeted development of psychological flexibility, and therapeutic use of self to build alliance and to model empathy, compassion, and a flexible relationship to experience.

Co-Construction of Goals

Although outcome research often focuses on increasing relationship satisfaction or avoiding relationship termination, couples present with a variety of problems and treatment goals, and those targets of treatment may change over the course of therapy. Like most couple therapists, ACT couple therapists do not prescribe a singular definition of relational health. Therefore, the first task is to decide together what will count as a successful end to therapy. At any point in the therapy, goals can be revisited and renegotiated. Goals, although collective, ought to be consistent with both partners' values.

Co-Construction of Problems

Problems are understood as obstacles that keep couples from realizing their goals. As suggested in another third-wave behavioral therapy, functional analytic therapy (Gurman, 2015), modifiable problems can be understood as behavioral excesses (e.g., a couple invests most of their energy in career and childrearing), behavioral deficits (e.g., a couple spends little time connecting intimately), and problems of stimulus control, or behaviors that are "out of place" (e.g., an excessively conflictual couple consisting of two lawyers who "take their work home" and conduct their relationship conversations like depositions). In ACT for individuals, the problem is usually conceived as suffering, or the unworkable desire to control inner experiences leading to psychological inflexibility and experiential avoidance. In ACT for couples, psychological inflexibility is thought to establish and maintain many relational problems, but it is not a necessary or sufficient cause of relational problems. Compatibility issues can be "baked in" to the relational life of couples, and these can only be managed by fostering acceptance. ACT for couples also follows systemic approaches in integrating the significance of the extended family, community, and world in the development of problems. However, human problems are endlessly rich and complex. As a pragmatic therapy, ACT follows the functional contextualist guideline that analysis need only proceed until a specific goal is achievable (Hayes, 1993).

Targeted Development of Psychological Flexibility

Once goals have been envisioned, the therapist works to develop in each partner the psychological flexibility required to alter any behavioral deficits, excesses, and problems of stimulus control that stand in the way of the couple's goals. Toward this end, ACT couple therapists have at their disposal the entire armamentarium of ACT-consistent exercises, metaphors, and protocols that are known to facilitate behavior change (Stoddard & Afari, 2014). And although interventions may focus primarily on effecting behavior change in one or both partners, these are usually deployed conjointly to allow the therapist to monitor the impact of each intervention on the couple system.

The Role of the Therapist

The therapist's role is to help the couple increase their awareness of the factors that influence their relational processes and interactions (e.g., past experiences in that relationship; uncomfortable thoughts, feelings or urges that arise during a couple transaction) and, building on that awareness, to learn new, workable behaviors consistent with their relationship values. The primary means through which the therapist helps couples develop this skill is through direct experience, often using metaphors and in-the-moment exercises. A good analogy is teaching someone to drive a car or play an instrument. Verbal instruction alone will never be sufficient. Humans need to engage in the action and let their bodies learn by doing. The same notion is true of the skills ACT couple therapists help partners learn.

Overall, the ACT couple therapist's stance is nonconfrontational and collaborative. Therapists relate to the couple from an equal, compassionate, genuine, and sharing perspective, and respect their ability to shift from ineffective to effective behavior. One way to do this is by modeling the supportive, respectful behavior desired from partners, and modeling the ability to roll with resistance in two valuable ways: by showing a willingness to experience one's own discomfort, and by resisting the urge to argue, lecture, or attempt to convince partners to think or act differently. Finally, therapists try not to express their judgments or opinions about couples' experiences.

Notably, priority is given to the "bonds" aspect of the therapeutic alliance (Bordin, 1979), a common factor of effective psychotherapies. ACT couple therapists work to create an atmosphere of profound acceptance to contain distress and encourage remoralization (Lebow, 2014). Moreover, ACT therapists model psychological flexibility in their interactions with clients (Hayes et al., 2012). Bringing this approach to couples may be particularly beneficial for the working alliance, as couple therapists can experience considerable anxiety when managing relationship dynamics in the therapy room (Shamoon, Lappan, & Blow, 2017). ACT couple therapists may strategically disclose their own feelings of insecurity or incompetence and model how to make room for these experiences even as the therapist works toward the valued therapeutic goal they share with their couple (Hayes et al., 2012).

Challenges for the ACT Couple Therapist

Beginning ACT couple therapists often find themselves confronted with several challenges. One challenge is to avoid the urge to help couples through advice giving, problem solving, or giving extra explanation or instruction. The ACT couple therapist allows the couple to arrive at realizations on their own and experience the confusion and frustration that inevitably come with learning these new skills. A second challenge facing beginning ACT couple therapists is to avoid the urge to inform couples of the meaning of metaphors or exercises either before presenting them or immediately afterward, which can undermine their impact. The ACT couple therapist practices noticing these urges when they arrive, then steps back and just "sits with" the urge to explain or direct couples. The challenge is to recognize and accept that couples may not get it in the way one wants or expects them to, let alone as quickly as one wants.

A third challenge arises when ACT couple therapists employ the critical learn-by-doing approach embraced in this therapy. Couples' minds bring forth rules, beliefs, attitudes, and interpretations that inevitably lead to resistance to this approach. They want to be told what they should learn rather than doing without knowing why beforehand. However, the use of metaphors and in-the-moment exercises can help to overcome these obstacles. A fourth challenge for both therapists and couples is the seemingly counterintuitive nature of the skills we want to help couples develop. ACT focuses on the *function* of one's thoughts, with the goal of increasing awareness of the thoughts and altering partners' responses to and relations with those thoughts. Thus, ACT couple therapists teach couples to allow uncomfortable or unhelpful thoughts to remain instead of trying to change their content. This approach is often surprising to couples, because they typically assume the goal is to reduce in-the-moment discomfort and distress brought on by thoughts or feelings. The ACT couple therapist indirectly challenges that assumption by encouraging the couple to focus on the function rather than the content of the thoughts and to allow those thoughts to exist. The goal is to be willing to allow those thoughts to exist while committing to behavior change in service of one's values. Relatedly, couples are often resistant to the notion that changing thoughts and feelings is not necessary for behavior change. The ACT therapist brings this resistance into session and uses it as material to practice the new skills. Indeed, acknowledging and bringing resistance into the session is critical for effective change in ACT couple therapy, as it represents the very experiential work central to this model.

Another facet of ACT couple therapy is an emphasis on experiencing a more fulfilling relationship, rather than symptom reduction. Although helping couples learn more effective conflict management strategies, for example, may be helpful, the goal is to help couples broaden their relationship to comprise healthy, rewarding functioning in all five relational domains. These two goals are somewhat similar to the dual goals targeted in most couple therapies—to both reduce negativity (i.e., symptoms) and increase positivity (e.g., fulfillment). Understandably, severely distressed couples find it challenging to focus on increasing positivity in the face of strong negativity in their relationship. Moreover, trying to increase the positivity can be quite difficult for severely distressed couples given that it requires partners to be emotionally vulnerable with each other at a time when they do not feel emotionally safe. Not surprisingly, this goal is typically met with resistance by couples, necessitating the therapist's ability to work with such resistance instead of challenging it.

Assessment, Treatment Planning, and Goal Setting

The assessment phase for ACT couple therapy includes two conjoint sessions, two individual sessions (one with each partner), and the administration of questionnaires. During this phase, emphasis is placed on the five multiple domains of couple functioning noted earlier (conflict, support, emotional intimacy, sexual relationship, and respect and control). Partners' degrees of psychological (in)flexibility are also evaluated as they relate to these relationship domains. The goals are to begin to identify the couple's shared or unshared relationship values, the relationship or partner cognitions on which they get stuck, and the memories that get linked to the present moment in times of relationship distress or heightened conflict.

The conjoint sessions are used to gather information about the couple's presenting problems, relationship history, relationship strengths, and levels of distress and commitment. The thorough assessment of couple functioning includes gathering information across the multiple domains of couple processes over time. One option is to use the semistructured Relationship Quality Interview (RQI; Lawrence et al., 2011). The goal is to assess and target all key relational domains in service of the goal of creating a more rewarding, fulfilling, relational life.

The individual sessions are conducted separately with each partner to gather information about personal histories that are relevant to the couple's current relationship. These include family-of-origin factors (e.g., quality of their parents' or caregivers' relationships), significant past romantic relationships, and significant physical or psychological health problems (e.g., depression, anxiety, chronic illness). When psychological symptoms are present and the partner has not already been given a diagnosis or is not in treatment, a formal assessment of psychopathology is recommended to help the partner get necessary medical or therapeutic care for the illness if these cannot be addressed within the couple therapy.

Questionnaires serve two goals: to gather additional information not obtained during the four assessment sessions and to serve as pretherapy data to track treatment progress. In addition to the relational functioning assessment, we recommend administering three types of measures. The first is a measure of global relationship satisfaction as a unitary construct given that it is almost always a target distal outcome for couple therapy, including ACT couple therapy. Two measures that are both brief and possess strong psychometric properties are Funk and Rogge's Couples Satisfaction Index (Funk & Rogge, 2007) and Norton's Quality of Marriage Index (Norton, 1983). The second type of measure assesses psychological, physical, and sexual aggression to aid in determining whether couple therapy is contraindicated. Here we recommend the short version of the Multidimensional Emotional Abuse Scale (Maldonado et al., 2020) and certain scales from the revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The advantage of these measures is that they capture specific behaviors in which either partner engages. It is imperative that the questionnaires be completed *prior to* the individual session, so the therapist may inquire about the context in which any reported aggression occurred, as well as whether either partner fears for their safety or has endured injuries from the abuse, both of which would suggest that couple therapy of any kind is contraindicated. The third type of measure assesses partners on the six ACT processes that we see as the key processes to be targeted in couple therapy to achieve healthy multidimensional relationship functioning and satisfaction. We recommend the Multidimensional Psychological Flexibility Inventory (MPFI; Rolffs, Rogge, & Wilson, 2018), which comprehensively assesses the six key dimensions of psychological inflexibility (experiential avoidance, lack of contact with present moment, self as content, fusion, lack of contact with values, and inaction) and the six key dimensions of psychological flexibility (acceptance, present-moment awareness, self as context, defusion, contact with values, and committed action). There are 60-item and 24-item versions, both of which have strong psychometric properties and norms.

The assessment sessions are followed by a conjoint feedback session. The purpose of the feedback session is to provide feedback about relational domain strengths and challenges and to introduce ACT couple therapy as a specific approach to be adopted during the treatment phase. Areas of relational strength are presented as protective factors in the relationship and domains in which the couple is functioning poorly are presented as opportunities for relational growth. This information is presented in such a way as to facilitate a discussion with the couple and to arrive at an agreed-upon plan for which domain(s) to target in the treatment plan. For example, a couple may have effective conflict management skills but feel emotionally disengaged and lack trust, indicating that emotional intimacy would be an important treatment target.

The other purpose of the feedback session is to introduce the experiential nature of ACT couple therapy and the framework that psychological inflexibility leads to relational suffering. Presenting this through metaphor and exercises rather than instruction is critical to framing the treatment phase within an ACT-consistent framework. One of our favorite ways to introduce the concept of experiential avoidance is the *clipboard metaphor* (see Harris, 2009). The clipboard represents unwanted, uncomfortable, or distressing internal experiences (thoughts, feelings, urges, or memories). The couple identifies specific thoughts or feelings that they are struggling to sit with or acknowledge. The therapist walks the couple through a series of activities with the clipboard (i.e., holding it in front of their own faces so they cannot see or interact with others, holding it out at arm's length in front of them until their arms get tired, letting it sit on their laps). The goal is to introduce to couples the notion that allowing their unwanted internal experiences about the relationship to be present frees them up to connect with each other and work on their relationship in a values-consistent manner.

Another technique we recommend is *the matrix* (Polk, 2021), in which the six ACT processes are presented in the context of a diagram with four quadrants and dichotomous categories on which to place the various components of ACT (see Figure 5.1). However, rather than identifying the six processes described earlier in this chapter, couples are guided through a series of experiential exercises designed to help them distinguish between (1) external experiences (what their partner actually says or does) and internal experiences (their interpretations of, feelings about, or memories that arise in response to what their partner says or does); (2) their unwanted internal experiences (uncomfortable emotions such as shame and guilt, hostile thoughts about their partner's motives) and any actions they choose in an effort to get rid of, control or change those unwanted internal experiences (get drunk or high, go for a run, watch TV); and (3) actions intended to move them away from the unwanted internal experiences (avoidant or distraction strategies) and actions that move them toward their relationship values (staying in an uncomfortable conversation because the relationship matters to them, sharing vulnerable emotions with their partner because emotional intimacy is important to them). The ultimate goal is to help couples stop the cycle of rehashing and reliving arguments and dysfunctional patterns and, instead, practice noticing their internal experiences instead of being consumed by them, identifying their relationship values relevant to the current situation, and intentionally choosing their words and actions based on those values rather than their internal experiences. The Matrix provides a way for couples to learn to pause before saying or doing something they regret during times of heightened emotion or when they get hooked on unhelpful cognitions about their partner or about their relationship.

For example, during a couple interaction, partners can choose to say or do something that moves them (1) toward their relationship values or (2) away from uncomfortable feelings. Similarly, couples are coached to distinguish between

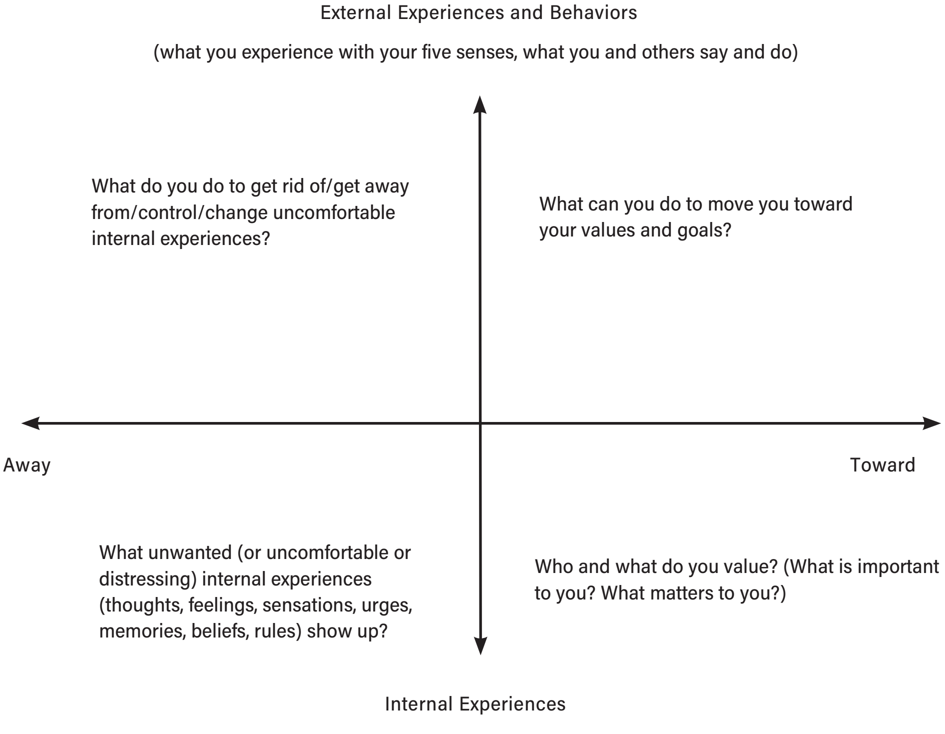

External Experiences and Behaviors
(what you experience with your five senses, what you and others say and do)
What do you do to get rid of/get away from/control/change uncomfortable internal experiences?
What can you do to move you toward your values and goals?
Away
Toward
What unwanted (or uncomfortable or distressing) internal experiences (thoughts, feelings, sensations, urges, memories, beliefs, rules) show up?
Who and what do you value? (What is important to you? What matters to you?)
Internal Experiences

FIGURE 5.1. Visual depiction of the ACT matrix. From Polk (2021). Reprinted with permission.

(1) what their partner says or does and (2) the internal thoughts and feelings they have about their partner's words or actions. Notably, there are endless metaphors and exercises that one can use to introduce the six processes of ACT in an accessible, jargon-free manner.

Strategic Focus of ACT Couple Therapy

Four strategic foci characterize ACT couple therapy: identifying couple values and promoting couple cohesion, targeting cognitive fusion, promoting committed couple action, and responding to feedback.

Identifying Couple Values and Promoting Couple Cohesion

Values are global qualities of action that individuals freely choose to serve as a "compass" to guide their choices. They are not to be confused with goals or any other specific outcome, as they are always available and identifiable irrespective of circumstances. In the language of RFT, values are a kind of *augmenting*, or an abstract ideal that functions as a verbal reward when one behaves in ways that are consistent with the ideal. For example, an individual comes home from work, sees that dinner has not been made despite a previously agreed-upon plan to do so, and feels a surge of anger and the urge to yell. Nevertheless, consistent with the couple's value of *respect* in their relationship, the individual makes a conscious decision to use a polite tone. In so doing, the person may feel a small sense of gratification for acting in a values-consistent manner. Opting for politeness in this context, based on a freely chosen value, has a markedly different quality from actions influenced by automatic thoughts or feelings that arise in the moment.

A strong common thread among different visions of ACT for couples (Dahl et al., 2014; Harris, 2009; Lev & McKay, 2017) is the conviction that couples are more likely to enjoy long and satisfying relationships when they are guided by shared values. In most couples, the original "spark" that once ignited passion at the start of their relationship fades over time. Without contact with the original reinforcers that fueled gratifying couple interaction, many couples flounder and begin to notice more of what they find aversive in each other. Therefore, it is often necessary, especially at the start of couple work, to have a frank discussion about what is, in fact, keeping a couple together. What about the relational context reinforces each partner, and what do they find punishing? Sources of reinforcement and punishment usually include the partners themselves but may also include elements of the wider context; partners may enjoy the material and social advantages—money, property, social connections—that their relationship makes possible. Many couples whose emotional bonds have attenuated stay together for the sake of their children or shared property. Still others live in a state of profound mutual ambivalence and struggle to explain just why they continue in the relationship. In any of these cases, great benefit can accrue from a functional analysis of the consequences each partner experiences as a function of staying in the relationship.

Once the functional analysis has proceeded and a sense of each partner's experience in the relationship has been clarified, the therapist can open a discussion of each partner's vision for their lives: their dreams, hopes, and longings. Embedded in the stories, emotions, and images are vital clues to the couple's individual and relational values. Moreover, even with high-conflict couples, there will be values that are shared between the partners. Parents, for example, often share a deeply felt commitment to their children's well-being, even if they disagree about the details of childrearing. Starting with a discussion around shared values can serve as a useful foundation from which to later discuss differences.

50TH ANNIVERSARY TOASTS

A useful experiential exercise to evoke individual and shared values may be found in the "50th Anniversary Toasts" (or 75th or 100th if the couple is very close to or past their 50th anniversary). A sample script for this exercise follows:

> "Imagine a fancy banquet hall lit with chandeliers. At the entrance, a sign says 'The 50th Anniversary of [partner 1] and [partner 2].' You and your partner are seated at the head table. You are surrounded by friends and family. You can even feel the spirit of loved ones long since passed. One by one, friends and family rise to toast the couple of the hour. In their toasts, the way they describe the two of you makes you think that despite all your difficulties, you have, by and large, somehow managed to become the couple you long to be. Now, if you're willing, I'd like each of you to take a moment to write down some of the ways you imagine your friends and family will have described you on that day."

RELATIONSHIP VALUE DOMAINS

The dimensions of the QRDF may be used to guide couples to identify a set of shared values they can use to build a workable and fulfilling life together.

Communication and Conflict Management. Couples who present with communication and conflict issues may call each other names and bring up past issues to throw in each other's faces. Often, partners in these relationships do not like how they feel or act while they are arguing but struggle to shift their behavior during a moment of heightened emotion. In this example, the therapist might remind the couple that conflict is an inevitable part of relationships and ask them how they would like to argue. Perhaps the partners endorse at least the notion of being respectful, purposeful, and kind during arguments, even if the specific behaviors fitting this description seem out of reach. This approach can move the conversation away from rehashing a recent argument and toward a discussion of their previously stated shared relationship values such as mutual respect.

Interpartner Support. People in relationships who struggle in this domain may have spent years longing for help from their partner or may have built thick walls of resentment as a result of providing support that went unacknowledged or unappreciated. Partners who have failed to provide the desired support can feel overwhelmed, guilty, or resentful themselves. They have detailed mental maps of how support goes wrong in the relationship. How would each partner like to give and receive support? Generosity, thoughtfulness, consideration, and constancy can be meaningful descriptors in this domain. At this juncture, it can be important to remind couples that the best way to effect change in their relationship is to focus on their own contributions; therefore, each partner can decide the manner in which they would like to receive support, but one partner cannot decide for the other what or how much support to provide.

Emotional Closeness and Intimacy. In many distressed couples, the last time partners can remember exhibiting values-consistent behavior in the domain of emotional closeness and intimacy was at the earliest stages of a relationship, when the fires of attraction were burning hottest. Childrearing, career, and other demands may have absorbed the partners' energies and eclipsed the emotional bond. Creative and future-oriented thinking may be important to identify new workable values in this domain, which might include vulnerability, openness, trustworthiness, playfulness, friendliness, and adventurousness.

Quality of the Sexual Relationship. Couples distressed in this domain often find themselves contending with cultural and familial messages about what constitutes "normal" sexual desire and activity. Men frequently view sex as a kind of performance in which they are expected to show up as impressive, powerful, and indefatigable. Women, in addition to feeling pressure to meet arbitrary standards of physical beauty, also internalize culturally transmitted standards of performance and may feel obligated to be receptive to sex without being overly interested in it (Sakaluk, Todd, Milhausen, & Lachowsky, 2014). Values discussions in this domain often involve identifying dominant cultural images and social scripts that partners have internalized throughout their lives. Workable, freely chosen values surrounding sex can be especially diverse and idiosyncratic. The therapist might ask partners what they learned about sexual communication from their parents and, subsequently, how they wish to communicate about sex in their current relationship. Doing so might help identify both internalized values and potentially desirable values around the sexual relationship they wish to have. Importantly, partners may ultimately combine internalized and desirable values in constructing the set for their own relationship. For example, partners may hold both internalized messages from their youth, such as openness and forthrightness, in combination with values they developed in adulthood, such as responsiveness and sensitivity.

Respect, Power, and Control. Power imbalances in romantic relationships can lead to significant distress, and equity often is an elusive yet worthy goal. Mixed-gender relationships can be especially challenging in this domain. As Rampage (2002) synthesizes: "Marriages in which the principle of equality between partners animates their everyday transactions are more satisfying (and less dangerous) than relationships in which partners struggle for power, or in which too much control is vested in one person" (p. 265). Although equality is regarded as an ideal for contemporary relationships, it is frequently unrealized (Maier, 2016). Therefore, couples whose distress might be relieved by greater equity in their relationships often need help to recognize and address power dynamics. Therapists can help couples elaborate their own vision of relational equity, respect, and agency. Workable values in this domain may include respectfulness, fairness, partnership, teamwork, reciprocity, and interdependence.

Targeting Cognitive Fusion

A core concept of ACT, cognitive fusion (Hayes, Strosahl, et al., 2012) refers to a rigid and unworkable relation between individuals and their own thoughts. Thoughts, which are conceptualized as self-talk or "covert speech," are an extremely powerful tool people use to continually review and evaluate past experiences, and to project into the future. The more attention and energy we devote to our internal chatter, the more the world around us fades from view. ACT supplies techniques to facilitate defusion, which reduces partners' absorption in their inner worlds by redirecting their attention to the information available to their five senses in the present moment (Bernstein et al., 2015). Dahl and colleagues (2014) discuss five "language traps" that may interfere with couple functioning. For our current purposes, we compress these into three broad categories: fusion with stories about the self; fusion with stories about the other; and fusion with standards, expectations, roles, and other rules. These categories are explained below, along with examples.

FUSION WITH SELF-STORIES

Partners in couple therapy present in the therapy room after a lifetime of successes and failures in navigating interactions with others. They have crafted mental narratives to make sense of the pain and pleasure that each interaction brings. In these narratives, characters are imbued with qualities thought to explicate their behavior: We think of ourselves as smart or foolish, hardworking or lazy, outgoing or shy, compassionate or cruel. Such stories can be useful when they help us to learn from the past and make plans. However, they may also lead us to ignore new information that could conflict with the old story and contribute to a more nuanced and flexible sense of self. An example of problematic fusion with self-stories may be found in partners whose sexual satisfaction is reduced by negative body image.

For example, Mark and Jacquelyn came to couple therapy to improve their sex life. As the therapist explored each partner's self-story related to sexuality, it became clear that Mark viewed his weight as making him undesirable and undeserving of pleasure. He insisted that he could not enjoy sex with Jacquelyn until he had lost enough weight to resemble the athletes he admired. Burdened with this self-story, he feared the feelings of shame that emerged when he would be naked with his partner. In this instance, Mark was invited to spend some time recording fused cognitions in a journal prior to a sexual encounter. He would list each judgment as it came to mind, recording them verbatim without elaboration. As these cognitions came in rapid succession but would also repeat themselves, he would acknowledge new iterations of each thought with a checkmark. One such list:

I'm so disgusting. √√
My gut is lumpy and weird. √√√
She says she likes my belly, but I don't believe her. √√√√
If I really wanted to change, I'd have gone to the gym. √
If I really wanted to change, I would stick to a diet. √

The act of acknowledging and monitoring his inner chatter was a wonderful first step before vulnerably sharing these thoughts with Jacquelyn. Through affirmations and challenging of these cognitions, Jacquelyn helped facilitate a revision of Mark's self-story. Notably, the goal was not to get rid of Mark's thoughts but to help him notice them as such rather than as provable facts. Eventually, Mark and Jacquelyn were able to enjoy their sex life even when the negative self-story intruded occasionally on his consciousness.

FUSION WITH "OTHER" STORIES

Just as our "selves" exist as verbal constructions in our heads, we represent others in our minds in the form of descriptions and explanations of their behavior. These verbal constructions can transform our perceptions of the other and blind us to ways in which our partner's attributes or behaviors are inconsistent with our ideas about them. Cognitive and social psychology contain numerous examples of how partners' perceptions of each other can be replete with adaptive and maladaptive bias (Fletcher & Kerr, 2013). The pragmatic truth criterion of ACT suggests that we do not try to eliminate bias or increase "accuracy" of partner perceptions, but we intervene when partners' perceptions of each other decrease their ability to behave in flexible and workable ways that serve the relationship. One approach to understanding relationships is to view love as a story (Sternberg, Hojjat, & Barnes, 2001). Partners of distressed couples often tell negative stories about each other that contrast dramatically with the relatively positive story of the early relationship. These negative stories impact relationship functioning in the present and can shape expectations for the future of the relationship.

Much like defusion from self-stories, partners can help each other defuse from the stories they have about their partners. For example, the therapist might help the couple to identify and share their stories with each other. The therapist would then encourage the couple to practice defusing from those stories together over the coming week, perhaps by writing down the stories when they arise. It would be important for the therapist to encourage the partners to jot down the thoughts as if writing a grocery list rather than a narrative or journal, to facilitate defusion rather than rumination. Alternatively, the couple might give the story a title (e.g., the "We Can't Fix This" story or the "We're Not Capable of Having a Healthy Relationship" story). The therapist then encourages the couple to practice noticing when that story joins an argument they are having and name the story when it does appear. These defusion strategies help partners disentangle the thoughts from the strong emotions or actions that often accompany them. Additionally, this shared practice can increase a feeling of connection and help the couple join in a shared goal.

FUSION WITH RULES

Perhaps the most distinctive contribution of ACT to couple work is an emphasis on exploring how rules operate in the couple's life. Rules are a necessary and largely adaptive aspect of human life. They help us to predict the consequences of our actions, make plans, and coordinate behavior with others. Rules can also be harmful, especially when they distort our experience of the environment and each other (Dahl et al., 2014). We are often unaware of the rules that govern our relationships. For example, many individuals fuse with the rule that their partners should know when they are upset and know how to make them feel better in any situation. To promote defusion from this rule, the ACT couple therapist would help the partner notice being fused with this rule. Subsequently, the therapist would help the partner practice noticing when that rule arises in the couple's interactions, identify the relationship values relevant to that same interaction (e.g., kindness), and commit to an action consistent with that value rather than being influenced by the rule.

Promoting Committed Couple Action

Many couples struggle with planning, deciding, and acting together as a couple. Partners in unhappy relationships often feel left out of important decisions, or they feel they must sacrifice their own desires for the good of the relationship. Partners may become resentful over time if they feel their own hopes and dreams are consistently unsupported within their relationship. Even when partners agree on certain goals, they may feel stymied by the pain and stress they encounter on the way to achieving them. Moreover, human development never ceases, and partners may grow apart.

Some ways committed couple action supports couple functioning include facilitation of egalitarian negotiation, increasing resilience to stress, and enhancing couple cohesion. One example that highlights all of these methods is the decision to raise children. Relationship quality suffers when couples "slide" into the decision to parent (Owen, Rhoades, & Stanley, 2013) and enter into parenthood as a reaction to interpersonal pressure rather than a joint decision based on freely chosen values. Moreover, the well-known (albeit usually temporary) reduction in couple satisfaction with the introduction of a first child can strain the resources of the strongest couples. Additionally, partners can vary in how quickly and easily they assume their role as parents, leading some partners to feel lonely or disempowered within their relationship. Open discussion of these issues can help couples organize their actions around freely chosen values that are shared.

Committed couple actions are those that are undertaken based on shared couple values. For example, David and Jennifer are a married couple in their 20s with two children under the age of 5. They are both distressed and believe that they are "bad parents," because they spend so much time working outside of the house instead of being with their children more. The therapist might start by asking what a "good parent" is, to help the couple identify their values around parenting. The couple states that it means "making sure their children feel loved." The therapist would then ask, "If I were a fly on the wall, what would I see you doing or hear you saying today that would let me know that you value making sure your children feel loved?" David might offer hugging them and saying, "I love you," and Jennifer might indicate putting her phone down when in the room with them and praising their efforts when they do something. The point is that the examples David and Jennifer identify are actions to which they can commit that are consistent with their values.

Responding to Feedback

It is important to emphasize that in ACT for couples, functional analysis does not end with each partner. Virtually all relational therapies attend to processes at the dyadic level and beyond (Lebow, 2014). At all stages in the therapeutic process, ACT couple therapists must attend to the ways in which the couple system responds to change. Any increase in one partner's ability to unhook from aversive private experiences may be registered by the other partner as a welcome change or a disruption in the relationship's well-worn pattern. Consider, for example, Linda's response to her partner Sandra's criticism of her for forgetting to take out the trash. If Linda's habitual response to Sandra's criticism has been to sullenly grab the trash and take it to the dumpster, Sandra may not be pleased to see Linda instead pausing thoughtfully to craft a verbal response in response to her criticism. ACT therapists who work with couples must be aware of and responsive to these shifts. In such a situation, an ACT couple therapist could explicitly identify this shift in action (i.e., Linda's thoughtful verbal response instead of an automated grabbing of the trash) and ask Sandra to share the resulting shift in her thoughts and feelings (i.e., "She is so useless!"). The therapist might then direct the couple to consider these shifts in the context of their previously agreed-upon values and their commitment to enacting those values.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

ACT couple therapy can easily be integrated with other types of couple therapy. For example, one might use ACT couple therapy techniques to help couples defuse from their unhelpful relational thoughts and emotions, then identify shared relationship values to guide their shared path forward as a couple. One of their shared relationship values may be "fun and romance," yet the partners may be unable to generate ideas for actions. Here, behavioral activation at the couple level may be helpful to bring into the therapeutic process.

ACT couple therapy is contraindicated when either partner discloses severe violence (e.g., choking, punching, kicking) or describes fear of injury. Other situations that might be contraindicated in other couple therapies are often still appropriate for ACT couple therapy. For example, if one partner were currently engaging in infidelity or one partner has pursued steps toward divorce, ACT couple therapy might be appropriate as part or all of the treatment plan. If these situations were known by both partners, an ACT couple therapist could guide the couple to examine their individual and relationship values more closely and, if pursuing divorce is incongruent with one or both partners' values, perhaps facilitate a change in paths to help the couple enact a more values-consistent life. Importantly, if pursuing divorce is, indeed, values-consistent, an ACT couple therapist could encourage commitment to acting on those values and help support the couple through that commitment. Similarly, a partner who suffers from a severe psychological disorder or chronic physical health problem that is poorly managed would likely benefit from couple-based interventions for emotional and physical health problems as supplemental to ACT couple therapy.

Empirical Support

In this section we provide a summary of the evidence demonstrating the links between ACT processes and couple functioning, followed by empirical support for ACT couple therapy as a psychological intervention.

Empirical Support Linking ACT Processes and Relational Functioning

Daks and Rogge (2020) conducted a recent systematic review and meta-analysis of the associations between psychological flexibility–inflexibility and aspects of both familial and romantic relational functioning. They identified 97 published studies that included an association between a dimension of psychological flexibility and an aspect of romantic relationship distress. Findings from their meta-analysis confirmed that people with higher psychological inflexibility, as well as their partners, experience lower relationship quality. Specifically, psychological inflexibility was associated with lower relationship satisfaction, sexual satisfaction, and emotional supportiveness, and with higher negative conflict, physical aggression, and attachment anxiety and avoidance.

Additionally, results of a moderated mediation study suggested several possible paths whereby high levels of experiential avoidance (a specific form of low psychological flexibility) can lead to interpersonal problems (Gerhart, Baker, Hoerger, & Ronan, 2014). Taken together, these findings suggest possible mechanisms whereby psychological inflexibility can exacerbate, and psychological flexibility can ameliorate, individual behaviors that can disrupt or impair couple relationships.

Empirical Support for ACT Couple Therapy

There is a wealth of empirical support demonstrating the effectiveness of ACT to treat a variety of individual problems and behaviors, including but not limited to posttraumatic stress disorder, depression, and chronic pain (see Gloster, Walder, Levin, Twohig, & Karekla, 2020, for a review of meta-analyses of the empirical status of ACT as a psychological intervention). Moreover, ACT is listed as an empirically supported treatment meeting the high standards set by multiple organizations. In contrast, empirical evaluation of ACT couple therapy is in its infancy, with only one case study design published on ACT couple therapy. Peterson, Eifert, Feingold, and Davidson (2009) implemented an ACT-based intervention with two distressed couples using a pretest–posttest design with follow-up that included measures of relationship functioning and ACT processes.

Notably, there exists a promising ACT-based intervention to prevent intimate partner violence. This intervention was developed to increase the ability of perpetrators to tolerate unwanted external stimuli (e.g., negative affect by one's partner) and concomitant internal distress and to respond flexibly, and in a values-consistent manner, to highly conflictual couple interactions (Langer & Lawrence, 2010a, 2010b; Lawrence, Mazurek, & Reardon, 2021; Reardon, Lawrence, & Mazurek, 2020; Zarling, Bannon, & Berta, 2019; Zarling, Bannon, Berta, & Russell, 2020; Zarling, Lawrence, & Marchman, 2015). This ACT-based intervention (administered to groups of men, not couples) has been recognized by the Department of Justice as an intervention demonstrating promising efficacy for the treatment of intimate partner violence.

CASE ILLUSTRATION

Eli and Martin were an unmarried couple referred for therapy by Eli's individual therapist. The individual therapist noted Eli's history of tumultuous family relationships and difficulty tolerating the thought that others might be upset with him.

Assessment Phase

Eli (age 35) and Martin (age 33) attended the first two sessions together. Both identified as White, cisgender, male, and gay. Eli described himself as a "secular Jew from the professional class" with close, if turbulent, connections to his family of origin. Martin had grown up Catholic but was no longer observant. He described himself as hailing from "a stereotypical big, working-class, Irish Catholic family." The couple had been involved for 4 years and living together for 3 and described problems with conflict resolution and open communication. Eli stated that his hope for therapy was that they "keep talking" when they disagree and eventually to come to an understanding or compromise. Martin stated that he wanted a better understanding of why he reacts as he does to thought-provoking or emotional discussions and better tools to address issues when they emerge. Martin acknowledged that he is not always forthcoming to Eli and could sometimes "make him jump through emotional hoops."

Eli and Martin met while both were employed at the same nonprofit institution. Eli found Martin to be mature, forthcoming, and emotionally self-aware. Martin found Eli intelligent, thoughtful, and compassionate. Both partners reported intense sexual attraction to each other that was still strong.

Eli

As an experienced and verbally intelligent consumer of therapy, Eli readily opened up in his individual assessment session. A development officer at his nonprofit, Eli described himself as a "do-gooder" and "underachiever" in his family. The only son of a physician and an attorney, Eli had an older and a younger sister, both of whom had found their way into management positions in the corporate world. Eli frequently found himself at odds with his sisters, who both had children and enjoyed taking cruises with their families. Eli explained that his sisters resented him for not making the kind of salary that would allow him to pay his own way on these family vacations. Arguments with his sisters could be greatly taxing for Eli. He might spend an hour arguing with them on the phone and later try to debrief with Martin. At these times, Eli found Martin an unsympathetic listener: "He didn't grow up in an enmeshed Jewish family with money." Moreover, Eli could find it very hard to be tolerant when Martin was in a bad mood: "I don't know if I'd call it the 'silent treatment,' but he can get really quiet when he's upset, and all I want at those times is to talk it out and get to some kind of resolution."

Martin was Eli's second long-term partner following a relationship of almost 10 years. Eli described his previous partner as "controlling," "narcissistic" and even "emotionally abusive" in a way that contrasted strongly with his relatively egalitarian relationship with Martin. Regarding their sexual relationship, Eli described himself and Martin as closely aligned in terms of how often they desired sex and willingness to ask for what they wanted sexually, both in and out of the bedroom. Finally, Eli's verbal report corroborated his intake questionnaire, which revealed no issues related to intimate partner violence or diagnosable psychopathology.

Martin

At his assessment session, Martin appeared cordial but somewhat less comfortable in the therapeutic setting. Martin was apologetic about his lack of experience in therapy. "It's always been a thing I know I should do, but that I never did." One of his hopes for therapy was to learn to communicate more openly and frequently, with not only his partner but also his family of origin. His father, a skilled union laborer, had passed away 6 years earlier from a sudden heart attack, and Martin had long felt guilt and regret over the infrequent communication and emotional distance that had long characterized his relationship with his father at the time of his passing. Martin had warm, if not especially close, relationships with his five siblings, all of whom were older. Martin reported being closer to his mother than to his father, but some tension existed in that relationship due to his mother's grudging acceptance of her son's sexuality.

Martin described his past romantic relationships as "not superserious" before Eli. He found Eli's emotional expressiveness refreshing. "He doesn't hesitate to tell me what he wants" in terms of affection and warmth. "I don't have to guess," he continued. On occasion, however, Eli's need for reassurance could result in Martin feeling as though he had little room for his own emotions and moods. For example, on a recent trip to the grocery store, when the couple approached an especially long line at the checkout, Martin let out an exasperated sigh. For the rest of the evening, it seemed, Eli was worried that Martin was in a bad mood generally or upset with him specifically. "By the time we got home, I really was in a bad mood," he recalled. "Eli kept asking, 'Are you okay? Are you mad at me?' I didn't say this to him, but inside, I kept thinking 'leave me the f--k alone.' Because that's how I am when I'm upset. I don't even want to be touched. I just want to stay at a safe distance from everyone until the feeling passes."

Feedback Session

In this session, the therapist planned to accomplish four tasks: (1) present Martin and Eli's preliminary case conceptualization, (2) identify at least one shared relationship value the couple could unite around, (3) provide an experiential exercise to introduce the six processes of ACT, and (4) assign homework. Prior to the session, the therapist reviewed the dimensions of relational functioning and hypothesized that cognitive fusion was constraining the couple's functioning primarily in the areas of support, emotional intimacy, and conflict. Differences in temperament and background were likely contributors as well. The therapist also planned to highlight the couple's strengths in the areas of respect/control and sexuality.

The therapist opened the session by outlining the couple's strengths, as well as challenges. He praised the couple for pursuing couple work at an early point in the relationship and noted Martin's openness to engaging in his first-ever course of therapy. The therapist also explained that although his model of couple therapy does not make prior assumptions about relationship functioning, it can be useful to work from a research-informed perspective on what "ingredients" are required for a successful relationship. The therapist might say:

> "This picture of couple functioning assumes that most well-functioning relationships involve being able to do five different kinds of things reasonably well: experience emotional closeness, trust, and safety; respect each other as autonomous adults; argue and problem-solve constructively; support each other through difficulties; and have a satisfying sex life. What I would like to know is, to what extent that picture of a 'healthy' relationship seems a good fit for you two?"

Eli and Martin generally agreed that each of these areas were important for them.

The therapist brought up a subject that both partners had raised in their individual sessions: their contrasting ways of responding to their own internal distress. The therapist used each partner's own language to stay close to their experience:

> "Eli, when you feel worried about something, you want to 'talk it out' and 'get to a resolution,' while Martin, when you're feeling anxious, you can be quiet or even withdrawn, thinking to yourself 'leave me the f—k alone,' which for you doesn't reflect hostility but a preference to process on your own before bringing problems to your partner. It's important to point out that these two ways of being are, by themselves, adaptive and workable, but in the context of your partnership, they can result in an escalated conflict that takes a relatively long time to resolve."

The therapist pointed out that the suffering each partner experiences when their conflicts are unresolved is a likely clue to the shared values of their relationship: "You wouldn't suffer if you didn't care so deeply." With the help of a list, the therapist asked the couple to select a few words that could, at least preliminarily, capture the relationship value that gives them the willingness to experience temporary discomfort. The couple chose "intimacy," "trust," and "compassion."

In the remaining time, the therapist used the Clipboard Metaphor to introduce the concepts of ACT and the different ways in which the couple might relate to their distressing thoughts and feelings. Their homework for the first week was to wait for conflicts to arise and simply to take note of their thoughts and feelings as they come and go during conflict.

Treatment Phase

Defusion Interventions

The first formal defusion exercise in this course of treatment was *Leaves on a Stream*, a guided meditative technique we described earlier in this chapter. This technique is a difficult one that requires practice for most couples. Introducing this activity early in the therapy was useful in establishing the expectation that sessions would feature experiential work designed to increase each partner's psychological flexibility. Equipped with an experience of perceiving thoughts without engaging with their content, Eli and Martin were able to understand their first homework assignment, to observe their thoughts while they were arguing. However, the couple's response to this homework assignment was rather mixed. When asked to recount his thoughts during conflict, Eli showed a tendency to engage with the content of the thoughts and quickly escalate into a wider-ranging discussion of his anxieties about the couple's future. Martin, on the other hand, seemed to struggle with remembering and articulating his thoughts in the moment. In their disappointment, the therapist sensed an opportunity to invite them to respond more flexibly to their own thoughts. "You may not believe me," he said, "but you two did a great job on your homework." The therapist praised their willingness to try to shift their awareness from the content of their thoughts to their context: the interpersonal process in the room and the couple's overarching goals and relationship values. He then prompted the couple to practice the skill in the present moment: "What are your minds giving you right now?" Eli responded first and promptly launched into his fears about the relationship generally, but before he could get far, the therapist asked him to pause and slow down. This was an opportunity for the therapist to introduce the idea of an *other-story*:

> "Eli, it sounds like your mind is doing a great job of trying to keep you safe. Generally, we spend most of our day reviewing memories of the past and projecting into the future, and we spend very little time in the present moment. Evolution has given human beings a huge leg up with language by allowing us to continually review the past and imagine the future. And from how you're talking, it sounds like you spend a lot of time in the future. That's why I said your mind is doing a good job of keeping you safe. It's doing the job it was designed to do. And while I'm still just getting to know you two, I want to raise the possibility that your mind is doing *such* a good job of protecting you from danger that it's not letting you spend as much time as you'd prefer pursuing the kind of experience in your relationship I know you want more of: *intimacy, trust,* and *compassion*."

For his part, Martin noted that the more time Eli spent processing his anxiety aloud, the more discouraged he felt. "I feel like I'm not doing a good job of helping Eli feel better." It seemed that Eli's other-story about Martin could activate one of Martin' self-stories. As Martin did not outwardly narrate the story, the therapist encouraged Martin to disclose some of its content: "Have you ever had this feeling before?" Martin recalled feeling helpless and unable to support his mother in her grief following the loss of her husband.

Having introduced the concept of self-stories and other-stories, the therapist assigned the same homework assignment as before, but with a slightly different twist.

> "I would like for you to catch yourselves telling a self-story or other-story. Now, you're not allowed to point out this behavior in *each other*. You only get to notice your *own* stories. I don't want you to try to figure out whether the story is accurate or to try to stop telling the story to yourself. All you have to do is notice it's happening. If you find this to be pretty easy to do, you can add another step. I'd like for you to notice any sensations that are present in your body."

Subsequent sessions involved building on the couple's awareness of the influence of their self-stories and other stories on their lives together, further practice in defusion from these stories, and refinement of and reorientation to their shared values. Moreover, as time went on, Eli and Martin began to grow in their awareness of the influence of unexamined rules in their lives and interpersonal roles they might find themselves automatically playing. For example, Martin viewed himself as a "troubleshooter" who "should be able to fix" problems as they arise. Hence, he had internalized a rule that not having a solution for Eli's distress meant that Martin had failed as a partner. "Not at all," Eli told him. "Most of the time, in fact, all I want is for you to listen." The therapist was able to support Martin in responding to his own feelings of helplessness and guilt in a new way: by noticing how his mind constructs a self-story around the emotions and draws his attention into the past and future. "You can always just thank your mind for keeping you safe and turn your attention to the information available in your environment, for example, to the feedback you receive from Eli when you are 'just listening.'" The therapist was also able to support Eli in responding to his own distress when Martin would need time to himself to process his emotions. "I think I thought that people stopped loving me when they were angry," said Eli, "and then magically went back to loving me when I pleased them again."

Responding to Feedback

Throughout the treatment, the therapist continually attended to the impact of defusion on the couple's relationship. For this couple, with partners at similar stages of individual development, similar visions of relationship success, and few difficulties in sharing power and exercising mutual influence, the promotion of individual growth presented little risk to the relationship. Other couples, for example, such as mixed-agenda couples whose commitment is in question, may have presented greater complexity. The most dramatic feedback in this case emerged not from the couple itself, but from Eli's family. As Eli experienced increased support and emotional safety with Martin, Eli's sisters seemed to sense their brother's focus shifting away from their priorities. The therapist encouraged Eli to generalize his increased distress tolerance in the context of his family. Eli found this challenging: "It's somehow easier to believe that Martin still loves me when he's angry than it is to believe that my sisters do when they're angry." However, Eli noted that power and respect worked differently in his family of origin than in his relationship with Martin. Perhaps he would not be seen as a full-fledged grownup in his family until he could afford expensive vacations. Fortunately for Eli, his partner did not share his sisters' expectations.

CONCLUDING COMMENTS

ACT is an empirically supported treatment that aims to increase psychological flexibility, or the capacity to experience the unavoidable pain of life, while taking actions based on freely chosen values. The model was developed for, and has largely proven effective to treat, a vast range of individual psychopathologies and presenting issues. We have articulated in this chapter ACT couple therapy as a comprehensive framework for treating relational functioning in a multidimensional, systemic, flexible way.

SUGGESTIONS FOR FURTHER STUDY

Harris, R. (2009). *ACT with Love: Stop struggling, reconcile differences, and strengthen your relationship with acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change*. New York: Guilford Press.

Lawrence, E., Brock, R. L., Barry, R. A., Langer, A., & Bunde, M. (2009). Assessing relationship quality: Development of an interview and implications for couple assessment and intervention. In E. Cuyler & M. Ackhart (Eds.), *Psychology of relationships* (pp. 173–189). New York: Nova Science.

REFERENCES

Bernstein, A., Hadash, Y., Lichtash, Y., Tanay, G., Shepherd, K., & Fresco, D. M. (2015). Decentering and related constructs: A critical review and metacognitive processes model. *Perspectives on Psychological Science, 10,* 599–617.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Dahl, J., Stewart, I., Martell, C. R., & Kaplan, J. S. (2014). *ACT and RFT in relationships: Helping clients deepen intimacy and maintain healthy commitments using acceptance and commitment therapy and relational frame theory.* Oakland, CA: New Harbinger.

Daks, J. S., & Rogge, R. D. (2020). Examining the correlates of psychological flexibility in romantic relationship and family dynamics: A meta-analysis. *Journal of Contextual Behavioral Science, 18,* 214–238.

Feliu-Soler, A., Montesinos, F., Gutiérrez-Martínez, O., Scott, W., McCracken, L. M., & Luciano, J. V. (2018). Current status of acceptance and commitment therapy for chronic pain: A narrative review. *Journal of Pain Research, 11,* 2145–2159.

Fletcher, G., & Kerr, P. (2013). Love, reality, and illusion in intimate relationships. In J. Simpson & L. Campbell (Eds.), *The Oxford handbook of close relationships* (pp. 306–320). New York: Oxford University Press.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21,* 572–583.

Gerhart, J. I., Baker, C. N., Hoerger, M., & Ronan, G. R. (2014). Experiential avoidance and interpersonal problems: A moderated mediation model. *Journal of Contextual Behavioral Science, 3,* 291–298.

Gloster, A. T., Walder, N., Levin, M., Twohig, M., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses. *Journal of Contextual Behavioral Science, 18,* 181–192.

Gurman, A. S. (2015). Functional analytic couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (pp. 192–223). New York: Guilford Press.

Harris, R. (2009). *ACT made simple.* Oakland, CA: New Harbinger.

Hayes, S. C. (1993). Analytic goals and the varieties of scientific contextualism. In S. C. Hayes, L. J. Hayes, H. W. Reese, & T. R. Sarbin (Eds.), *Varieties of scientific contextualism* (pp. 11–27). Oakland, CA: New Harbinger.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition.* New York: Kluwer Academic/Plenum.

Hayes, S. C., Barnes-Holmes, D., & Wilson, K. G. (2012). Contextual behavioral science: Creating a science more adequate to the challenge of the human condition. *Journal of Contextual Behavioral Science, 1,* 1–16.

Hayes, S. C., Brownstein, A. J., Zettle, R. D., Rosenfarb, I., & Korn, Z. (1986). Rule-governed behavior and sensitive to changing consequences of responding. *Journal of the Experimental Analysis of Behavior, 45,* 237–256.

Hayes, S. C., & Hayes, L. J. (1992). Some clinical implications of contextualistic behaviorism: The example of cognition. *Behavior Therapy, 23,* 225–249.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change.* New York: Guilford Press.

Langer, A., & Lawrence, E. (2010a). Emotion regulation and experiential avoidance in intimate partner violence. In J. A. Jaworski (Ed.), *Advances in sociology research* (Vol. 6, pp. 73–101). New York: Nova Science.

Langer, A., & Lawrence, E. (2010b). Toward an integrated, empirically supported theory of intimate partner violence. In K. Osterman (Ed.), *Indirect and direct aggression* (pp. 357–374). New York: Peter Lang.

Lawrence, E., Barry, R. A., Brock, R. L., Bunde, M., Langer, A., Ro, E., . . . Dzankovic, S. (2011). The Relationship Quality Interview: Evidence of reliability, convergent and divergent validity, and incremental utility. *Psychological Assessment, 23,* 44–63.

Lawrence, E., Brock, R. L., Barry, R. A., Langer, A., & Bunde, M. (2009). Assessing relationship quality: Development of an interview and implications for couple assessment and intervention. In E. Cuyler & M. Ackhart (Eds.), *Psychology of relationships* (pp. 173–189). New York: Nova Science.

Lawrence, E., Mazurek, C., & Reardon, K. (2021). Comparing recidivism rates among domestically violent men enrolled in ACTV versus Duluth/CBT. *Journal of Consulting and Clinical Psychology, 89,* 469–475.

Lebow, J. (2014). *Couple and family therapy: An integrative map of the territory.* Washington, DC: American Psychological Association.

Lev, A., & McKay, M. (2017). *Acceptance and commitment therapy for couples: A clinician's guide to using mindfulness, values, and schema* *awareness to rebuild relationships*. Oakland, CA: New Harbinger.

Maier, C. A. (2016). Conceptualizing household distribution of labor from feminist theory: Why power matters in psychotherapy. *Marriage and Family Review, 52,* 413–420.

Maldonado, A. I., Farzan-Kashani, J., Sun, S., Pitts, S. C., Lorenzo, J. M., Barry, R. A., & Murphy, C. M. (2020). Psychometric properties and factor analysis of a short form of the Multidimensional Measure of Emotional Abuse. *Journal of Interpersonal Violence*. [Epub ahead of print]

Norton, R. (1983). Measuring marital quality: A critical look at the dependent variable. *Journal of Marriage and the Family, 45,* 141–151.

Owen, J., Rhoades, G. K., & Stanley, S. M. (2013). Sliding versus deciding in relationships: Associations with relationship quality, commitment, and infidelity. *Journal of Couple and Relationship Therapy, 12,* 135–149.

Peterson, B. D., Eifert, G. H., Feingold, T., & Davidson, S. (2009). Using acceptance and commitment therapy to treat distressed couples: A case study with two couples. *Cognitive and Behavioral Practice, 16,* 430–442.

Polk, K. (2021). *The ACT Matrix Academy*. http://theactmatrixacademy.com.

Rampage, C. (2002). Marriage in the 20th century: A feminist perspective. *Family Process, 41,* 261–268.

Reardon, K. W., Lawrence, E., & Mazurek, C. (2020). Adapting acceptance and commitment therapy to target intimate partner violence. *Partner Abuse, 11,* 447–465.

Rolffs, J. L., Rogge, R. D., & Wilson, K. G. (2018). Disentangling components of flexibility via the hexaflex model: Development and validation of the Multidimensional Psychological Flexibility Inventory (MPFI). *Assessment, 25,* 458–482.

Rosenfarb, I., & Hayes, S. C. (1984). Social standard setting: The Achilles heel of informational accounts of therapeutic change. *Behavior Therapy, 15,* 515–528.

Sakaluk, J. K., Todd, L. M., Milhausen, R., & Lachowsky, N. J. (2014). Dominant heterosexual sexual scripts in emerging adulthood: Conceptualization and measurement. *Journal of Sex Research, 51,* 516–531.

Shamoon, Z. A., Lappan, S., & Blow, A. J. (2017). Managing anxiety: A therapist common factor. *Contemporary Family Therapy: An International Journal, 39,* 43–53.

Sternberg, R. J., Hojjat, M., & Barnes, M. L. (2001). Empirical tests of aspects of a theory of love as a story. *European Journal of Personality, 15,* 199–218.

Stoddard, J. A., & Afari, N. (2014). *The big book of ACT metaphors: A practitioner's guide to experiential exercises and metaphors in acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2). *Journal of Family Issues, 17,* 283–316.

Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression: A review. *Psychiatric Clinics, 40,* 751–770.

Wadsworth, M. E., & Markman, H. J. (2012). Where's the action?: Understanding what works and why in relationship education. *Behavior Therapy, 43,* 99–112.

Wakefield, S., Roebuck, S., & Boyden, P. (2018). The evidence base of acceptance and commitment therapy (ACT) in psychosis: A systematic review. *Journal of Contextual Behavioral Science, 10,* 1–13.

Zarling, A., Bannon, S., & Berta, M. (2019). Evaluation of acceptance and commitment therapy for domestic violence offenders. *Psychology of Violence, 9,* 257–266.

Zarling, A., Bannon, S., Berta, M., & Russell, D. (2020). Acceptance and commitment therapy for individuals convicted of domestic violence: 5-year follow-up and time to reoffense. *Psychology of Violence, 10,* 667–675.

Zarling, A., Lawrence, E., & Marchman, J. (2015). A randomized controlled trial of acceptance and commitment therapy for aggressive behavior. *Journal of Consulting and Clinical Psychology, 83,* 199–212.

EMOTION-CENTERED, PSYCHODYNAMIC, AND MULTIGENERATIONAL APPROACHES

CHAPTER 6

Emotionally Focused Couple Therapy

Susan M. Johnson, Stephanie A. Wiebe, and Robert Allan

BACKGROUND

Emotionally focused couple therapy (EFT) has contributed substantially to the field of couple interventions. In particular, it has led the way in developing interventions that change emotion regulation and responses in ways that lead to increased emotional responsiveness and bonding interactions.

EFT is an integration of an experiential/gestalt approach with an interactional/family systems approach. It is a constructivist approach, in that it focuses on the ongoing construction of present experience (particularly experience that is emotionally charged), and a systemic approach, in that it also focuses on the construction of patterns of interaction with intimate others. In the early 1980s, Sue Johnson and Leslie Greenberg integrated these ideas into what was then the beginnings of an integrative approach to couple relationships that privileged the power of emotions to transform relationships. This integration provides a strong theoretical basis for addressing the nature of romantic love through attachment theory, the deeply emotional experience inherent in attachment love relationships, the way attachment interactions play out in an attachment system, and the need for a therapeutic space of unconditional positive regard, genuineness, and attunement in order to facilitate emotionally significant systemic shifts in relationships.

Experiential Influences

The experiential perspective has always seen the wisdom of focusing on emotional responses and using them in the process of therapeutic change. In couple therapy, emotional signals are the music of the couple's dance, so a focus on emotion in therapy seemed most natural. In this and other ways, EFT shares commonalities with traditional humanistic approaches (Johnson, 2020). EFT adheres to the following basic premises of experiential therapies:

1. The therapeutic alliance is healing in and of itself and should be as egalitarian as possible. In attachment terms, it offers a safe haven where emotion can be tolerated and reflected on, and a secure base where experience can be explored and expanded.
2. The acceptance and validation of each partner's experience is a key element in therapy. In couple therapy, this involves an active commitment to validating each person's experience of the relationship, without marginalizing or invalidating the experience of the other. The safety created by such acceptance then allows each partner's innate self-healing and growth tendencies to flourish. This safety is fostered by the authenticity and transparency of the therapist.
3. The essence of the experiential perspective is a belief in the ability of human beings to

make creative, healthy choices, if given the opportunity. The therapist helps to articulate the moments when choices are made in the relationship drama and supports partners to formulate new responses. This approach is essentially nonpathologizing. It assumes that we find ways to survive and cope in dire circumstances, when choices are few, then later find those ways limiting and inadequate for creating fulfilling relationships and lifestyles.

4. Experiential therapies encourage an examination of how inner and outer realities define each other; that is, the inner construction of experience evokes interactional responses that organize the world in a particular way. These patterns of interaction then reflect and, in turn, shape inner experience.
5. Experiential approaches take the position that we are all formed and transformed by our relationships with others. By helping partners change the shape of their relationships, the EFT therapist is also helping them reshape their sense of who they are.
6. Experiential approaches attempt to foster new corrective experiences that emerge as part of personal encounters in the here and now of the therapy session. The therapist not only tracks how partners encounter and make sense of the world but also helps them to expand that world.

Systemic Influences

EFT falls within the tradition of family systems therapies, drawing on systemic techniques—particularly those of Minuchin's structural approach, with its focus on the enactment of "new" patterns of interaction. The unique contribution of EFT is the use of emotion in breaking destructive cycles of interaction. By helping partners identify, express, and restructure their emotional responses at key points in patterned interactions, the EFT therapist helps them to develop new responses to each other and a different "frame" on the nature of their problems. Partners can then begin to take new steps in their dance, to interrupt destructive cycles such as demand–withdraw, and to initiate more productive ones.

EFT adheres to the following basic premises of family systems theory:

1. Causality is circular, so it cannot be said that action *A* "caused" action *B*. For example, the common couple pattern in which one partner demands interaction, while the other tries to withdraw, is a self-perpetuating feedback loop. It is not possible to say whether the "demanding" led to the "withdrawal" or whether the "withdrawal" led to the "demanding."
2. We must consider behavior in context. This is summed up by the familiar phrase "The whole is greater than the sum of the parts"; that is, to be understood, the behavior of one partner must be considered in the context of the behavior of the other partner. And the behavior of each partner is to be considered in the context of their lives, including experiences of marginalization and sources of resilience (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim).
3. The elements of a system have a predictable and consistent relationship with each other. This is represented by the systems concept of homeostasis and is manifested in couples by the presence of regular, repeating cycles of interaction.
4. All behavior is assumed to have a communicative aspect. What is said between partners, and the manner in which it is communicated, define the roles of the speaker and the listener. The nature of a relationship, and that of participants, is implicit in every content message and is seen in the way participants talk to each other. Levels of communication may also conflict. "I am sorry—okay?" can communicate dismissal and be heard as commentary on the unreasonable nature of an injured party rather than as a sincere apology.
5. The task of the family systems therapist is to interrupt repetitive, negative cycles of interaction, so that new patterns can occur. Systems theory in itself does not offer direction as to the nature of these new patterns; it only requires that they be more flexible and less constrained. To define such a direction, a theory of intimate relatedness is needed.

The Experiential–Systemic Synthesis in EFT

Experiential and systemic approaches to therapy both focus on present experience rather than historical events. Both view people as fluid or "in process" rather than as possessing a rigid character that is resistant to change. The focus of experiential approaches is traditionally within the person, whereas systemic therapies focus on the interactions between people.

In the experiential–systemic synthesis of EFT, there is a focus on both the cycles of interaction between people and the core emotional experiences of each partner underlying it. The word "emotion" comes from a Latin word meaning "to move." Emotions are identified and expressed as a way to help partners move into new stances in their relationship dance—stances that they then integrate into their sense of self and their definition of their relationship.

Attachment Theory

EFT is attachment-based in that the attachment bond between partners is viewed as the driving force shaping intrapsychic experience and interactional patterns in romantic relationships (Johnson, 2020).

The main tenets of attachment theory most relevant to EFT include the following:

1. Seeking and maintaining contact with significant others is a primary motivating principle for human beings that has been "wired in" by evolution. In other words, attachment is an innate survival mechanism operating throughout the lifespan, "from the cradle to the grave" (Bowlby, 1969, p. 208).
2. Dependency in relationships is normal and necessary for human health and well-being. Healthy dependency promotes autonomy and individual growth. The experiences and behaviors that constitute healthy dependency may be expressed differently and relate to developmental stages across the lifespan and are embedded in cultural contexts. Nonetheless, dependency itself is a normal and universal experience.
3. Connection with key others offers a safe haven and protection from danger. Research in affective neuroscience has supported "social baseline theory," the idea that inaccessibility of attachment figures—physical or psychological—represents a threat to our safety that is encoded in our nervous systems as a danger cue; that is, our normal baseline reality is one that is social and attached, and the absence of attachment figures in and of itself produces stress (Coan et al., 2017). Security in key relationships helps us regulate our emotions, process information effectively, and communicate clearly.
4. Attachment relationships provide a secure base from which to explore inner and outer worlds and promote growth and autonomy.
5. Accessibility and responsiveness foster secure attachment bonds. When attachment figures engage, respond, and attune reliably, the relationship becomes more secure. Lack of consistent engagement and responsiveness or inaccessibility leads to insecurity in the relationship.
6. Fear, illness, and stress activate attachment needs. It is precisely when stress is high and partners are vulnerable that the attachment system is triggered. While more secure partners turn quickly to collaborative efforts to seek support, solve problems, and alleviate distress, less secure partners have difficulty engaging emotionally and responding to each other, particularly in these moments of stress.
7. Separation distress normally results in proximity-seeking behaviors. When key attachment figures cannot be reached or do not respond in times of need, distress—whether manifesting outwardly or only inwardly—is inevitable.
8. Inner working models of attachment comprise views of self and other and provide an inner "map" of how to navigate relationships based on experiences in relationships accumulated thus far. These maps may be relatively insecure or relatively secure. Security in relationships is associated with a model of others as dependable and trustworthy, and a model of the self as lovable and entitled to care. Such models promote flexible and specific ways to attribute meaning to a partner's behavior (e.g., "He's tired; that's why he's grouchy—it's not that he is trying to hurt me").

EFT in the Context of Contemporary Couple Therapy

EFT is consonant with the most recent research in attachment, neuroscience, and observational studies pointing to the significant role of emotional engagement in couple relationship functioning (Coan et al., 2017; Gottman & Driver, 2005). The process of change in EFT is one of structuring small steps toward emotional engagement, so that partners can soothe, comfort, and reassure each other.

Given that development of EFT was based on the universal phenomena of attachment and emotion, the theory can be flexible enough to attune to specific partners and couples in terms of gender identity, sexuality, ethnicity, race, and culture. Furthermore, the attachment focus in EFT aligns with a depathologizing stance toward dependency regardless of gender and culture. In this way, EFT is in line with recommendations for feminist-informed therapies that inherently challenge gender-based constraints, work to increase personal agency, and "develop egalitarian relationships characterized by mutuality, reciprocity, intimacy and interdependency" (Haddock, Schindler Zimmerman, & MacPhee, 2000, p. 165).

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

Perspective on Relationship Health

A healthy relationship, in EFT terms, is a secure attachment bond. Such a bond is characterized by mutual emotional accessibility and responsiveness. This bond creates a safe environment that optimizes partners' ability to regulate their emotions, process information, solve problems, resolve differences, and communicate clearly. The research on adult attachment has demonstrated that secure relationships are associated with higher levels of intimacy, trust, and satisfaction, as well as personal health and well-being (Mikulincer & Shaver, 2016).

In adult relationships, attachment security involves interdependence and mutual accessibility, responsiveness, and engagement (Johnson, 2020). Adult attachment, when compared to attachment between children and caregivers, is more mutual and reciprocal. It is less concrete (e.g., adults need to touch their loved ones less because they carry them around with them as cognitive representations) and physical intimacy evolves into adult sexuality that connects adult partners, just as holding connects mother and child.

Attachment security allows us to feel safe enough to be curious and open to new evidence and enables us to deal with ambiguity (Mikulincer & Shaver, 2016). It may be that secure individuals are better able to articulate their tacit assumptions and see these as relative constructions rather than absolute realities. In general, attachment insecurity constricts and narrows how cognitions and affect are processed and organized, and so constrains key behavioral responses. Secure individuals are more able to engage in coherent, open, and direct communication that promotes responsiveness in their partner, and to disclose and to respond to the partner's disclosures. Confidence in the partner's responsiveness fosters empathy and the ability to see things from the partner's point of view.

Perspective on Relationship Distress

EFT looks at distress in relationships through the lens of attachment insecurity and separation distress (Johnson, 2020). When attachment security is threatened, human beings respond in predictable sequences. Typically, anger is the first response. This anger is a protest against the loss of contact with the attachment figure. If such protest does not evoke responsiveness, it can become tinged with despair and coercion, and evolve into a chronic strategy to obtain and maintain the attachment figure's attention. The next step in separation distress involves clinging and seeking, which then give way to depression and despair. Finally, if all else fails, the relationship is mourned and detachment ensues. Aggressive responses in relationships have been linked to attachment panic, in which individuals regulate their insecurity by becoming controlling and abusive to their partners (Mikulincer & Shaver, 2016).

The EFT perspective fits well with the recent research findings in attachment, neuroscience, and observational studies pointing to the significant role of emotional engagement in couple relationship functioning and the negative impact of emotional disengagement (Coan et al., 2017; Gottman & Driver, 2005). From this perspective, expression and regulation of emotion are key factors in determining the nature and form of close relationships. Absorbing states of negative affect (where everything leads into this state and nothing leads out) characterize distressed relationships (Gottman & Driver, 2005). In EFT, we speak of an "alarm being constantly on" in a distressed relationship and the "noise" blocking out other cues. Emotional disengagement predicts divorce better than the number or outcome of conflicts, and "stonewalling" has been found to be particularly corrosive in couple relationships (Gottman & Driver, 2005). This perhaps explains why a lack of responsiveness directly threatens attachment security, thus inducing helplessness and rage.

Research suggests that rigid interaction patterns, such as the familiar demand–withdraw pattern, can be poisonous for relationships. These negative interaction patterns are framed in EFT as a cycle that maintain attachment insecurity and make safe emotional engagement impossible. It is worth noting that the endemic nature of cycles, such as criticize–pursue followed by defend–withdraw, is predictable from attachment theory. There are only a limited number of ways to deal with the frustration of the need for contact with a significant other. One way is to increase attachment behaviors to deal with the anxiety generated by the other's lack of response (and perhaps appear critical in the process). The other's response may then be to avoid and distance oneself from perceived criticism. Research findings from attachment and affective neuroscience suggest that the creation of soothing interactions at such times has the power to redefine close relationships (Coan et al., 2017; Mikulincer & Shaver, 2016). Research on the impact of the pursuer–softening event suggests that these deeply vulnerable and emotionally engaged interactions are associated with improvements in relationship satisfaction and attachment security (Burgess Moser, Dalgleish, Johnson, Wiebe, & Tasca, 2018).

THE PRACTICE OF EFT

Key Principles

The key principles of EFT can be summarized as follows:

1. A collaborative alliance offers a couple a secure base from which to explore the relationship. The therapist is best seen as a process consultant to the couple's relationship.
2. Emotion is primary in organizing attachment behaviors and the ways self and other are experienced in intimate relationships. Emotion guides and gives meaning to perception; motivates and cues attachment responses; and, when expressed, communicates to others and organizes their response (Johnson, 2020). The EFT therapist privileges emotional responses and deconstructs reactive, negative emotions, such as anger, by expanding them to include marginalized elements, such as fear and helplessness. The therapist also uses newly formulated and articulated emotions, such as fear and longing or assertive anger, to evoke new steps in the relationship dance. Emotion transforms partners' worlds and their responses rapidly and compellingly, and evokes key responses, such as trust and compassion, that are difficult to evoke in other ways.
3. The attachment needs and longings of partners are viewed as essentially healthy and adaptive. It is the way such needs are enacted in a context of perceived insecurity that creates problems. The EFT therapist actively promotes "effective dependency"—that is, dependency that empowers and supports individual efficacy and autonomy in each partner.
4. Problems are maintained by the ways in which interactions are organized and by the dominant organization of emotional experience on the part of each partner in the relationship. Affect and interaction form a reciprocally determining, self-reinforcing feedback loop. The EFT therapist first has to deescalate negative interaction patterns and the reactive emotions associated with them. The therapist then helps partners shape new cycles of positive interaction in which positive emotions are fostered and negative emotions can be regulated in ways that do not compromise safe emotional connection.
5. Change occurs through new emotional experience in the context of attachment-salient interactions as they occur in session. New or reformulated experience translates into new signals to partners. These signals constitute a new music that shapes new patterns of interaction.
6. In couple therapy, the "client" is the relationship between partners. The attachment perspective on adult love offers a map to the essential elements of such relationships. Problems are viewed in terms of adult insecurity and separation distress. The ultimate goal of therapy is the creation of new cycles of secure bonding that offer an antidote to negative cycles and positively redefine the nature of the relationship.

The three tasks of EFT, then, are (1) to create a safe, collaborative alliance; (2) to access, reformulate, and expand the emotional responses that guide the couple's interactions; and (3) to restructure those interactions in the direction of the accessibility and responsiveness that build secure, lasting bonds.

The Structure of the Therapy: An Overview

The therapist has three primary tasks in EFT that must be properly timed and completed. The first task, creating an alliance, is considered in a later section. The second task is to facilitate the identification, expression, and restructuring of emotional responses. The therapist focuses on the "vulnerable" emotions (e.g., fear/anxiety, shame, and sadness) that play a central role in the couple's cycle of negative interactions. The therapist stays close to the emerging or leading edge of the couple's experience and uses humanistic–experiential interventions to expand and reorganize that experience. These include reflection, evocative questions (e.g., "What is it like for you when . . . ?"), validation, heightening (e.g., with repetition, metaphor, and imagery), and empathic conjecture. Such conjecture is always done tentatively and in very small increments.

In the third task, the restructuring of interactions, the therapist begins by tracking the negative cycle that constrains and narrows the partners' responses to each other. The therapist uses structural systemic techniques such as reframing and choreographing new relationship responses and events. Problems are reframed in terms of cycles and of attachment needs and fears. So, the therapist may ask someone to share specific fears with their partner, thus creating a new kind of dialogue that fosters secure attachment.

In a typical session, the therapist constantly cycles through five moves that build in intensity as therapy evolves called the "tango." Each of the five moves is like a step in the dance of the therapy session. In the first step, "reflect present process," the therapist reflects the process of interaction ("You stay distant and careful, expecting criticism, so then you react to his distance and become lonelier, feel dismissed, and express anger. The more anger you express, the more careful he then becomes"). In the second step, "deepening," the therapist then moves into deepening one partner's level of engagement and exploration of emotion ("It is so hard for you to hear criticism; you go into feeling overwhelmed and hopeless"). In the third step, "enactments," the therapist sets up an enactment whereby expanded experience is communicated to the partner ("Can you tell her, 'I become paralyzed with the fear of failing and upsetting you—so I stand still and stop responding'?"). In the fourth step, "process the enactment," this enactment that expands a partner's interactional repertoire is engaged at a deeper level by asking both partners to share what it was like to hear the new message and to express new feelings. Any negative responses are contained and explored. In the fifth step, "integrate and validate," the therapist gives an overview of what has just occurred, so that it can be coherently integrated ("You are both so afraid and confused, but look at what you just did, right here. You took risks and reached for each other. That is amazing. It takes courage and love to do that").

Stages and Steps of Intervention

The process of change in EFT has been delineated into nine treatment steps. The therapist leads the couple through these steps in a spiraling fashion, as one step incorporates and leads into the other.

Stage One: Cycle Deescalation

Step 1: Identify the relational conflict issues between the partners.
Step 2: Identify the negative interaction cycle where these issues are expressed.
Step 3: Access the unacknowledged, attachment-oriented emotions underlying the interactional position each partner takes in this cycle.
Step 4: Reframe the problem in terms of the cycle, underlying emotions that accompany it, and attachment vulnerabilities and needs.

The goal, by the end of Step 4, is for the partners to have a metaperspective on their interactions. They are framed as unwittingly creating, but also being victimized by, the cycle of interaction that characterizes their relationship. Step 4 is the conclusion of the deescalation phase. The therapist and the couple shape an expanded version of the couple's problems—a version that validates each person's reality and encourages partners to stand together against the common enemy of the negative cycle. The partners begin to see that they are, in part, "creating their own misery." If they accept the reframe, the changes in behavior they need to make may be obvious. For most couples, however, the assumption is that if therapy stops here, they will not be able to maintain their progress. A new cycle that promotes attachment security must be initiated.

Stage Two: Changing Interactional Positions

Step 5: Promote identification with disowned attachment needs and aspects of self. Such attachment needs may include the need for reassurance and comfort. Aspects of self that are not identified with may include a sense of shame or unworthiness.
Step 6: Promote each partner's acceptance of the other's experience.
Step 7: Facilitate the expression of needs and wants to restructure the interaction based on new understandings and to create bonding events.

The goal, by the end of Step 7, is to have withdrawn partners reengage in the relationship and actively state the terms of this reengagement. For example, a spouse might state, "I do want to be there for you. I know I zone out. But I can't handle all this criticism. I want us to find another way. I won't stand in front of the tidal wave." The goal also is to have more blaming partners "soften" and ask for their attachment needs to be met from a position of vulnerability. This "softening" often has the effect of pulling for empathic responsiveness from a partner. When both partners have completed Step 7, a new form of emotional engagement is possible, and bonding events can occur. These events are usually fostered by the therapist in the session, but they also occur at home. Partners are then able to confide in and seek comfort from each other, becoming mutually accessible and responsive.

Stage Three: Consolidation and Integration

Step 8: Facilitate the emergence of new solutions to old problems.
Step 9: Consolidate new positions and cycles of attachment behavior.

The goal here is to consolidate new responses and cycles of interaction—for example, by reviewing the accomplishments of the partners in therapy, and helping the couple create a coherent narrative of their journey into and out of distress. The therapist also supports the couple in solving concrete problems that have been destructive to the relationship. As stated previously, this is often relatively easy given that dialogues about these problems are no longer infused with overwhelming negative affect and issues of relationship definition.

The Role of the Therapist in Alliance Building

The therapeutic alliance is an essential ingredient of change across couple therapy models (see also Chapter 13, "Common Factors in Couple Therapy," in this volume, by Davis), and EFT is no different in this regard, with higher alliance related to better outcomes (Brubacher & Wiebe, 2019).

The creation of the alliance in EFT is based on the techniques of humanistic–experiential therapies. The EFT therapist attempts to be genuine, emotionally present, and available, focusing on empathic attunement and demonstrating acceptance of both partners. Humanistic therapies in general take the stance that the therapist should not hide behind the mask of professionalism but should attempt to be nondefensive and authentic. As therapists, we assume that the alliance must always be monitored and that any potential break in this alliance (and there will surely be at least one such break in a course of therapy) must be attended to and repaired before therapy can continue. The alliance is viewed in attachment terms as a secure base that allows for the exploration and reformulation of emotional experience and engagement in potentially threatening interactions.

Assessment and Goal Setting

Assessment in EFT comprises an interview to establish the therapeutic alliance, learn about the couple's relationship history, then explore what it is that brings them to therapy. The therapist begins to identify the negative cycle of interaction that typifies the couple's complaint. The therapist may either observe the cycle actually being played out in the session or begin carefully to track the cycle using an attachment frame to begin to understand each partner's responses in the relationship. Briefly, the therapist wants to find out exactly how the cycle begins, who says and does what as the cycle unfolds, and how it concludes. In this assessment phase, the partners may or may not begin to identify spontaneously the emotions and attachment needs underlying their positions in the cycle. The therapist may facilitate this by asking questions (e.g., "What was that like for you?"), and by validating attachment needs (e.g., "Of course, it makes so much sense that you need to feel that you're in it together"). At this early stage, expressed emotions tend to be rather superficial.

Although EFT is a present-focused therapy, a small amount of relationship history is obtained during the assessment phase. Partners may be asked how they met, what attracted them to each other, and at what point the present problems began to manifest themselves. Life transitions and shifts (e.g., birth of children, retirement, immigration) associated with the beginning of the problem and with partners' cultural heritages are particularly noted. Each partner's history of early attachment relationships is important to understand, which can be assessed with questions such as "Who held and comforted you when you were small?" The answers to such questions give the therapist a sense of the expectations, fears, and typical responses each partner learned in early attachment relationships that may be brought into the current relationship. It also gives the therapist a sense of whether safe attachment is familiar or foreign territory.

The therapist then asks partners about their specific treatment goals and what they hope to gain from therapy. The response to this question tends to be the inverse of the complaints solicited at the beginning of the assessment. Initially, partners were asked what they were unhappy about, but at this point in the assessment they are asked how they would like their relationship to be and are helped to specify particular changes they want to make. The therapist listens for the longing on the other side of dissatisfaction and complaints. Usually, these goals express or reflect some form of attachment need (e.g., to feel more connected, to feel like a team, to feel safer together, to feel heard and understood).

Questionnaires may be administered to assess relationship satisfaction (e.g., the Dyadic Adjustment Scale [DAS; Spanier, 1976]), and attachment (e.g., the Experiences in Close Relationships Scale [ECR; Brennan, Clark, & Shaver, 1998]). Furthermore, questionnaires and assessment tools specific to EFT are available in the workbook for therapists (*Becoming an EFT Therapist*; Johnson et al., 2005), as well as a workbook for couples (*An Emotionally Focused Workbook for Couples*; Kallos-Lilly & Fitzgerald, 2014). These EFT-specific measures can provide useful qualitative information about each person's feelings, reactions, and perceptions of their partner.

The process of assessment usually evolves, with one or two conjoint sessions followed by one individual session with each spouse. These individual sessions serve to deepen the alliance with the therapist, to provide an opportunity for each person to elaborate on perceptions of the other partner and on relationship problems, to assess attachment history, and to allow the therapist to ask sensitive questions about physical and sexual abuse in past attachment relationships and in the current relationship. In the initial conjoint session, the relational focus of the goals and process of therapy is outlined, including issues around confidentiality. Specifically, if one partner discloses information relevant to the relationship that has not been shared with the other partner, it is encouraged to reveal this information in the next couple of sessions. Keeping secrets, particularly secrets about alternative relationships that offer apparent escape from the trials of repairing the primary relationship, is presented as undermining the objectives of therapy and the partner's goals.

Goals consistent with the therapeutic principles are agreed upon. EFT therapists attempt to be transparent about the process of change and explain how and why they intervene whenever doing so seems appropriate. For instance, if a partner wants to renew passion in the relationship, the therapist breaks down the process into intermediate goals, suggesting that the couple will first need to deescalate the negative interactions.

Process and Technical Aspects

Once the alliance is established, there are two basic therapeutic tasks in EFT: (1) the exploration and reformulation of emotional experience and (2) the restructuring of interactions.

Exploring and Reformulating Emotion

The following interventions are used in EFT to address the first task:

1. Reflecting emotional experience.
    - *Example*: "Could you help me to understand? I think you're saying that you become so anxious, so 'edgy' in these situations that you find yourself wanting to hold on to and get control over everything—that the feeling of being 'edgy' gets overwhelming. Is that it? And then you begin to get very critical with your wife. Am I getting it right?"
    - *Main functions*: Focusing the therapy process; building and maintaining the alliance; clarifying and ordering the emotional responses underlying interactional positions.
2. Validation.
    - *Example*: "You feel so alarmed that you can't even focus. When we're that afraid, we can't even concentrate. Is that it?"
    - *Main functions*: Legitimizing responses and supporting partners to continue to explore how they construct their experience and their interactions; building the alliance.
3. Evocative responding. Expanding, by open questions, the trigger, somatic response, associated desires and meanings, and action tendency that constitute an emotional response.
    - *Examples*: "What's happening right now, as you say that?"; "What's that like for you?"; "So when this occurs, some part of you just wants to run—run and hide?"
    - *Main functions*: Expanding elements of experience to facilitate the reorganization of that experience; formulating unclear or marginalized elements of experience; and encouraging exploration and engagement.
4. Heightening experience. Using repetition, images, metaphors, or enactments to deepen a partner's emotional engagement.
    - *Examples*: "So could you say that again,

directly to her, that you do shut her out?"; "It seems like this is so difficult for you, like climbing a cliff—so scary"; "Can you turn to him and tell him? 'It's too hard to ask. It's too hard to ask you to take my hand.' "
  - *Main functions*: Highlighting key experiences that organize responses to the partner and new formulations of experience that will reorganize the interaction.

5. Small empathic conjectures or interpretations at the leading edge of experience.
   - *Example*: "You don't believe it's possible that anyone could see this part of you and still accept you. Is that right? So you have no choice but to hide?"
   - *Main functions*: Clarifying and formulating new meanings, especially regarding interactional positions and definitions of self.

These interventions—together with markers or cues as to when specific interventions are used, and descriptions of the process partners engage in as a result of each intervention—are discussed in more detail elsewhere (Johnson, 2020).

Restructuring Interventions

The following interventions are used in EFT to address the second task:

1. Tracking, reflecting, and replaying interactions.
   - *Example*: "So what just happened here? It seemed like you turned from your anger for a moment and appealed to him. Is that okay? But Jim, you were paying attention to the anger and stayed behind your barricade, yes?"
   - *Main functions*: Slows down and clarifies steps in the interactional dance; replays key interactional sequences.
2. Reframing in the context of the cycle and attachment processes.
   - *Example*: "You freeze because you feel like you're right on the edge of losing her, yes? You freeze because she matters so much to you, not because you don't care."
   - *Main functions*: Shifts the meaning of specific responses and fosters more positive perceptions of the partner.
3. Restructuring and shaping interactions. Enacting present positions, enacting new behaviors based on new emotional responses, and choreographing specific change events.
   - *Examples*: "Can you tell him? 'I'm going to shut you out. You don't get to devastate me again' "; "This is the first time you've ever mentioned being ashamed. Could you tell him about that shame?"; "Can you ask him, please? Can you ask him for what you need right now?"
   - *Main functions*: Clarifies and expands negative interaction patterns; creates new kinds of dialogue and new interactional steps/positions, leading to positive cycles of accessibility and responsiveness; titrates risks (e.g., "If it is too hard to share this, can you just tell him how very hard it is to share right now?").

Interventions for Impasses in Therapy

The most common place for the process of change to reach an impasse and become mired down is Stage Two. This is particularly true when a therapist is attempting to shape positive interactions to foster secure bonding and asks a blaming, critical person to begin to take new risks with their partner. Often, if the therapist affirms the difficulty of learning to trust and remains hopeful and engaged in the face of any temporary reoccurrence of distress, then the couple will continue to move forward.

The therapist may also set up an individual session with each partner to explore the impasse and soothe the fears associated with new levels of emotional engagement. The therapist can also reflect the impasse, painting a vivid picture of the couple's journey and its present status, and inviting the partners to claim their relationship from the negative cycle. This can be part of a general process of heightening and enacting impasses. A partner who can actively articulate their stuck position in the relationship dance feels the constraining effect of this position more acutely. So, by sadly stating to the partner, "I can never let you in. If I do . . . ?," they are beginning to challenge the stuck position. The partner often can then respond in reassuring ways that allow the other partner to take small new steps toward trust.

Attachment theorists have pointed out that incidents in which one partner responds negatively, or fails to respond, at times of urgent need seem to influence the quality of an attachment relationship disproportionately (Mikulincer & Shaver, 2016). These incidents, which we call "attachment injuries," shatter positive and/or confirm negative assumptions about attachment relationships and the dependability of one's partner. Negative attachment-related events, particularly abandonments and betrayals, often cause seemingly irreparable damage to close relationships. Many partners enter therapy with the goal of not only alleviating general distress but also bringing closure to such events, thereby restoring lost intimacy and trust.

During the therapy process, these events—even if they occurred long ago—often reemerge in an alive and intensely emotional manner, much like a traumatic flashback, and overwhelm the injured partner. These incidents, which usually occur in the context of life transitions, loss, physical danger, or uncertainty, can be considered "relationship traumas." When the other partner then fails to respond in a reparative, reassuring manner, or when the injured partner cannot accept such reassurance, the injury is compounded. As the partners experience failure in their attempts to move beyond such injuries and repair the bond between them, their despair and alienation deepen. For instance, a husband's withdrawal from his wife while she suffers a miscarriage, as well as his subsequent unwillingness to discuss this incident, becomes a recurring focus of the couple's dialogue and blocks the development of new, more positive interactions.

Attachment theory helps explain the extreme emotional adversity of isolation and separation, particularly at times of increased vulnerability, and how the presence of, and ability to receive support from, a responsive and attuned significant other attenuates the psychological impacts of traumatic events, whereas the absence of such support appears to impede recovery (Zurbriggen, Gobin, & Kaehler, 2012). This theoretical framework offers not only an explanation of why certain painful events become pivotal in a relationship but also an understanding of what the key features of such events will be, what impact they will have on a particular couple's relationship, and how they can be optimally resolved.

The process of resolving attachment injuries has been outlined in the attachment injury resolution model (AIRM; Makinen & Johnson, 2006; Zuccarini, Johnson, Dalgleish, & Makinen, 2013). Through this model, the injured partner articulates the impact of the injury and its attachment significance, while their partner is supported in hearing and understanding, allowing the injured partner to deepen and more fully articulate the primary emotions and loss of attachment security resulting from the injury. Upon hearing this articulated pain and loss, the injuring partner can begin to express responsibility and remorse. The injured partner is supported as they risk asking for the comfort and caring from the partner that were unavailable at the time of the injury. In the last step, partners are then able to construct together a new narrative of the event. This narrative is ordered and includes, for the injured partner, a clear and acceptable sense of how the other partner came to respond in such a distressing manner during the event.

Once the attachment injury is resolved, the therapist can more effectively foster the growth of trust, the occurrence of softening events, and the beginning of positive cycles of bonding and connection. Research has shown that couples who moved through this full process of attachment injury resolution in EFT are more likely to demonstrate significant increases in relationship satisfaction, trust, and forgiveness (Makinen & Johnson, 2006), and maintain these changes over three years (Halchuk, Makinen, & Johnson, 2010). The key components of the AIRM model have been explored and validated in qualitative research and linked to key EFT interventions that facilitated the process (Zuccarini et al., 2013).

Termination

In Stage 3 of treatment, the therapist is less directive, and the partners themselves begin the process of consolidating their new interactional positions and finding new solutions to problematic issues in a collaborative way. As therapists, we emphasize each partner's shifts in position. For example, we frame a more passive and withdrawn husband as now powerful and able to help his wife deal with her attachment fears, whereas we frame his wife as needing his support. We support constructive patterns of interaction and help the couple put together a narrative that captures the change that has occurred in therapy and the nature of the new relationship. We emphasize the ways the couple has found to exit from the problem cycle and create closeness and safety. Any relapses are also discussed and normalized. If these negative interactions occur, they are shorter, are less alarming, and are processed differently, so that they have less impact on the definition of the relationship. The partners' goals for their future together are also discussed, as are any fears about terminating the sessions. At this point, the partners express more confidence in their relationship and are ready to leave therapy. We offer couples the possibility of future booster sessions, but this is placed in the context of future crises triggered by elements outside the relationship rather than any expectation that they will need such sessions to deal with relationship problems per se.

MECHANISMS OF CHANGE

Change in EFT is seen as emerging from a process of incremental steps with each partner toward the edge of their inner emotional experience, ordering and assembling that experience in a way that is validating to both the person and the relationship, and reframing that experience in terms of attachment-based fears and longings, and the partners' escalating cycles of distress as efforts at reconnecting and reestablishing a secure bond. This involves expanding experience to include marginalized or hardly synthesized elements that then give new meaning to the experience. Once each partner's experience of relatedness takes on new color and form, the partners can move their feet in a different way in the interactional dance. For instance, "edginess" and irritation expand into anxiety and anguish. The expression of anguish then brings a whole new dimension into an irritated partner's sense of relatedness and their dialogue with their partner. Experience becomes reorganized, and the emotional elements in that experience evoke new responses to and from the partner. So, as the irritated partner becomes more connected with their fear and aloneness (rather than contempt for their partner), they want to reach for their partner and ask for comfort. Partners encounter and express their own experience in new ways that then foster new encounters and forms of engagement with each other. Experience is reconstructed, and so is the dance between partners.

The research on the process of change in EFT supports the view that engaging with and expanding emotional experience is associated with improved relationship outcomes (Brubacher & Wiebe, 2019). Greater depth of experiencing, as measured using the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), in the most significant sessions as identified by couples is associated with greater improvements at termination (Dalgleish, Johnson, Moser, Lafontaine, et al., 2015) and better maintenance of those improvements at 2-year follow-up (Wiebe, Johnson, Moser, Dalgleish, & Tasca, 2017). Greater depths of experiencing are characterized by statements that show attention to and expression of inner experience in a way that feels alive, vivid, and emergent. EFT therapists foster greater depths of experiencing by exploring emergent emotions and encouraging their expression (Brubacher & Wiebe, 2019). Interestingly, it is the greatest depth of experiencing the couple is able to maintain (i.e., mode score for the session) in the best session that best predicts follow-up outcomes as opposed to their highest level per se, suggesting that repetition is key (Wiebe, Johnson, Moser, et al., 2017).

Two main therapeutic change events are thought to occur in Stage 2 of EFT that shift the partners' dance in a fundamental way, paving the way for more secure connecting. The first is withdrawer reengagement, in which the more withdrawn partner begins to engage in the emotional life of the relationship by exploring and expressing their own, previously withheld, feelings and attachment needs to the partner, culminating in an accepting and supportive response from the partner who had previously been unaware of these deeper experiences of their partner. Although the withdrawer reengagement process is thought of as an "event," it has been found to occur rather as a recursive and cyclical process, often involving support from the partner along the way (Lee, Spengler, Mitchel, Spengler, & Spiker, 2017).

The second key therapeutic event in EFT is pursuer softening. In a complete pursuer-softening event, a vulnerable request is made by a usually hostile partner for reassurance or comfort, and the partner who had previously taken a withdrawn stance in the relationship responds to this request in an attuned and supportive way. The completion of a pursuer-softening event has been found to predict more relationship satisfaction change and greater improvement in attachment security across EFT sessions (Burgess Moser et al., 2016, 2018).

Here are some examples of the softening partner's progress through such an event:

"I just get so tense, you know. Then he seems like the enemy."

"I guess maybe I am panicked—that's why I get so enraged. What else can you do? He's not there. I can't feel that helpless."

"I can't ask for what I need. I have never been able to do that. I would feel pathetic. He wouldn't like it; he'd cut and run. It would be dreadful." (The partner then invites and reassures.)

"This is scary. I feel pretty small right now. I would really—well, I think (*to the partner*) I need you to hold me. Could you just let me know you care, you see my hurt?"

There are many levels of change in a softening. The ones most easily identified follow:

- There is an expansion of experience that includes accessing attachment fears and the longing for contact and comfort. Emotions tell the partners what they need.
- There is an engagement of a partner in a different way. Fear organizes a less angry, more affiliative stance. The frightened partner has put their emotional needs into words and changed their part of the dance. New emotions prime new responses/actions.
- A new view of the "softening" partner is offered to the other partner. The husband in the previous example sees his wife in a different light, as afraid rather than dangerous, and is pulled toward her by her expressions of vulnerability.
- A new, compelling cycle is initiated. In the previous example, she reaches and he comforts. This new connection offers an antidote to negative interactions and redefines the relationship as a secure bond.
- A bonding event occurs in the session. This bonding is reflected in the term "hold-me-tight conversation," which is used in the EFT relationship education program to describe a moment when a withdrawn partner is open and responsive and a blaming partner can soften and openly reach for caring, resulting in mutual responsiveness.
- There are shifts in both partners' sense of self. Both can comfort and be comforted. Both are defined as lovable and entitled to care in the interaction, and as able to redefine and repair their relationship.

Research also suggests (Bradley & Furrow, 2004) that certain interventions, such as evocative responding, are crucial in facilitating the deepening of emotion necessary to complete these softening events, and that the depth of therapist presence is a key factor in facilitating these deep emotional shifts (Furrow, Edwards, Choi, & Bradley, 2012). For a therapist to be able to guide a couple in the direction of such an event and help the partners shape it, the therapist has to be willing to engage emotionally. The therapist has to learn to have confidence in the process, in the inherent pull of attachment needs and behaviors, and in couples' abilities to reconfigure their emotional realities when they have a secure base in therapy. Even so, not every couple is able to complete a softening. Some couples improve their relationship, reduce the spin of the negative cycle, attain a little more emotional engagement, and decide to stop there.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

EFT has been used with many different couples facing many different kinds of issues. The EFT model, grounded in attachment theory, aims to help couples build the kind of resilience that research has shown to be characteristic of attachment security (Mikulincer & Shaver, 2016; Wiebe & Johnson, 2016). Following this approach, individual mental and physical health, as well as life stressors, grief, and so forth, are viewed through the lens of attachment in which greater security plays a regulating, soothing, and adaptive role, whereas insecurity often plays into the development or worsening of symptoms and adding stress to life challenges. Placing "individual" problems in their relational context enables a couple to find new perspectives on and ways of dealing with such problems.

EFT has more recently been applied to couples with more varied ethnic backgrounds (Linhof & Allan, 2019; Liu & Wittenborn, 2011; Nightingale, Awosan, & Stavrianopoulos, 2019) and to same-sex couples (Allan & Johnson, 2017; Zuccarini & Karos, 2011). The nuances and adjustments to the process that are necessary in working with diverse couples have been expanded theoretically (i.e., Allan & Johnson, 2017; Liu & Wittenborn, 2011; Zuccarini & Karos, 2011), and research on this topic is necessary and ongoing.

Theoretical development and research on the EFT model across a range of mental health challenges including depression, anxiety, trauma, and addictions supports the benefits of EFT not only for relationship distress but also for symptom reduction (MacIntosh & Johnson, 2008; Weissman et al., 2018; Wittenborn et al., 2019). In particular, strong research results have demonstrated the efficacy of EFT in reducing depressive symptoms for partners with depression (Denton, Wittenborn, & Golden, 2012; Dessaulles, Johnson, & Denton, 2003; Wittenborn et al., 2019).

Diverse Gender and Sexuality

EFT is used with same-gender, including gay and lesbian, couples, and although special issues are taken into account, these relationships both reflect the same attachment realities as those of cisgender heterosexual partners in mixed-gender relationships and require special attention to issues that are specific to these populations (Allan & Johnson, 2017; Allan & Westhaver, 2018). Particular aspects of the stories of couples of diverse gender identities and sexual orientations that represent significant attachment themes need to be addressed. For these couples, particular themes of high attachment significance may include encounters with discrimination and prejudice, threats to safety, and other forms of additional stress that may be faced from family, community, and broader society, as well as the possible internalization of these realities into internal working models of self and other (see also Chapter 23 on queer couples, in this volume, by Coolhart). Additionally, couples of diverse gender identities and sexual orientations face higher levels of stress due to living in heteronormative societal structures, which activates the attachment system, placing pressure on the attachment bond (Cook & Calebs, 2016). Notably, couples diverse in gender identity and sexuality appear to have particular strengths that may facilitate the therapeutic process in EFT, including responsiveness to partner influence, emphasis on equality, and growth experiences in the process of self-affirmation and expression that may expand and strengthen models of self and other (Gottman et al., 2003). As a model, EFT is well positioned to help diverse couples navigate the minority stress and buffer the effects of experiences with prejudice and discrimination these couples face, drawing on the resilience inherent in a secure attachment bond (Allan & Johnson, 2017).

In terms of gender, EFT appears to fit with the criteria for a gender-sensitive intervention. EFT focuses on connection/mutuality and validates the need for a sense of secure connectedness across all genders, regardless of societal gender norms that may place pressure on male partners to suppress expression of emotion and attachment needs. The ability to express feelings and needs, share power, and to trust is inherent in the creation of a secure adult bond.

Diverse Race and Ethnicity

Couples of diverse ethnic and racial backgrounds, as well as intercultural couples, also face particular challenges in their relationships and in the course of EFT (Karakurt & Keiley, 2009; Linhof & Allan, 2019). In particular, intercultural couples are often faced with managing differing expectations, worldviews, and language barriers, as well as discrimination and the existence of oppressive messaging about motivations behind their union (Linhof & Allan, 2019). Moreover, couples of diverse ethnic and racial backgrounds in general deal with the effects of discrimination and oppression that place stress on partners and activate the attachment system (Karakurt & Keiley, 2009). It is imperative that the EFT therapist working with racially and ethnically diverse couples engage actively in the fostering of a co-construction of narratives with these couples that contextualizes the layers of personally and socially constructed meanings about self and relationship; done well, this maps onto explorations of the view of self and other so pertinent to the attachment bond (Karakurt & Keiley, 2009; Linhof & Allan, 2019; Nightingale et al., 2019). This is especially important given that the "task alliance"—that is, whether the couple perceives the tasks of therapy as relevant—is a significant predictor of outcome in EFT (Linhof & Allan, 2019). Couples benefit most from EFT when it accurately reflects and engages the couple in a process that aligns well with their own understandings of what is helpful; for diverse couples, this may require bridging the culturally related gaps between therapist and couple or even between partners themselves.

Couples Facing Health Concerns

Research also demonstrates that EFT works well with couples facing relationship distress in the context of going through serious health concerns. The attachment system is activated in times of illness and stress, placing extra pressure on an attachment bond. There is evidence indicating that experiencing illness is a risk factor for relationship distress, and on the other side, evidence that more secure couples are buffered from deleterious relationship effects (see also Chapter 28 on medical issues, in this volume, by Ruddy & McDaniel). EFT has been shown to be effective for couples with chronically ill children (Gordon-Walker, Johnson, Manion, & Clothier, 1996), with ongoing improvements in the 2 years after ending therapy (Cloutier, Manion, Walker, & Johnson, 2002). Research has also demonstrated support for EFT to help alleviate relationship distress among distressed couples facing cancer (McLean, Walton, Rodin, Esplen, & Jones, 2013).

Trauma and Posttraumatic Stress Disorder

EFT has also been used extensively for couples in which one partner has posttraumatic stress disorder (PTSD) resulting from physical illness, violent crime, war trauma, or childhood sexual abuse (Johnson, 2002). EFT appears to be particularly appropriate for traumatized couples, perhaps because it focuses on emotional responses and attachment. PTSD is essentially about the challenge of regulating highly charged affective states, in which attachment relationships play a key role (Basham, 2008).

Trauma increases the need for protective attachments; at the same time, it undermines the ability to trust and therefore to build such attachments. Insecure attachment undermines the protective resource of an attachment bond from the psychological effects of trauma, while prolonged symptoms of posttraumatic stress itself negatively impact relationships, with those with more severe posttraumatic stress symptoms more likely to go through relationship dissolution or divorce (Barazzone, Santos, McGowan, & Dohaghay-Spire, 2019; Franz et al., 2014). If the EFT therapist can foster the development of a more secure bond between the partners, then this not only improves the couple relationship but also helps the partners to deal with the trauma and mitigate its long-term effects. In general, with these couples, cycles of defense, distance, and distrust are more extreme, and emotional storms and crises must be expected. The therapist has to pace the therapy carefully, containing emotions that the trauma survivor is unable to tolerate. Risks must be sliced thin, and support from the therapist must be consistent and reliable. Trauma survivors often swing between extreme needs for closeness and extreme fear of letting anyone close. This ambivalence has to be expected and normalized in therapy. The therapist also has to expect to be tested and, in general, has to monitor the always fragile alliance constantly. EFT for trauma couples has shown evidence of effectiveness for survivors of childhood sexual abuse (Dalton, Greenman, Classen, & Johnson, 2013; MacIntosh & Johnson, 2008) and veterans with PTSD (Weissman et al., 2018).

Depressed Partners

Research has firmly established an association between relationship distress and depression, with support for a model whereby relationship distress contributes to depressive symptoms based in predictive models and longitudinal research (see also Chapter 26 on depression or anxiety, in this volume, by Whisman, Beach, & Davila). Attachment theory views depression as an integral part of separation distress that arises after protest and clinging/seeking behaviors have not elicited responsiveness from an attachment figure. Research indicates that the more insecure individuals perceive themselves to be and the less close they feel to their partners, the more relationship distress seems to elicit depressive symptoms (Mikulincer & Shaver, 2016). Depressed individuals describe themselves as anxious and fearful in their attachment relationships marked by rumination, negative views of self, and reassurance-seeking attempts that are not satisfied in the relationship (Cortés-García, Takkouche, Rodriguez-Cano, & Senra, 2020; Mikulincer & Shaver, 2016). Attachment theory also suggests that one's model of self is constantly constructed in interactions with others, so problematic relationships result in a sense of self as unlovable and unworthy. From the perspective of EFT and attachment theory, depression is viewed as a symptom of the despair inherent in facing blocks to accessing a responsive and engaged other. Support for this view has been strengthened by accumulating research demonstrating that depressive symptoms can be ameliorated significantly by EFT (Denton, Burleson, Clark, Rodriguez, & Hobbs, 2012; Dessaulles et al., 2003; Wittenborn et al., 2019).

Predictors of Success

The effects of EFT have been found not to be qualified by education, income, length of marriage, interpersonal cognitive complexity, traditionality, or level of religiosity (Dalgleish, Johnson, Moser, Lafontaine, et al., 2015; Denton et al., 2000; Wiebe, Johnson, Moser, et al., 2017). Racial, ethnic, and religious background have not been sufficiently diverse in the research to reliably test these as predictors of outcome, and almost all previous EFT research is limited to mixed-gender couples assumed to be heterosexual and cisgender.

Theoretically relevant variables appear to predict outcomes. It seems that couples with higher levels of attachment anxiety and emotional control at baseline tend to show greater improvements across EFT sessions (Dalgleish, Johnson, Moser, Lafontaine, et al., 2015). Furthermore, it does not seem like initial levels of emotional self-awareness or emotional control impede emotional engagement in the process of EFT nor the completion of significant therapeutic events

(Dalgleish, Johnson, Moser, Wiebe, et al., 2015). Therefore, contrary to any expectation that couples would need to be inherently emotionally expressive in order to benefit from EFT, it seems that level of emotionality prior to beginning EFT does not impede the process, and those couples least engaged with their emotions may in fact benefit most.

Potential Contraindications

Violence in Relationships

The primary contraindication to the use of EFT occurs when the therapist believes that emotional vulnerability is not safe or advisable. The most obvious situation involves ongoing physical abuse. In this case, partners are referred to specialized domestic violence treatment programs (see also Chapter 17 on partner aggression, in this volume, by Epstein et al.). They are offered EFT only after this therapy is completed and the risk of violence is greatly reduced. It is important that the felt safety of a partner who has been abused is the primary criterion for couple therapy readiness rather than an abusive partner's assessment that the behavior is now under control.

Violence in the couple relationship should be assessed carefully. Consideration should be given to frequency, severity, risk of physical harm, feelings of safety on the part of the abused partner, whether the violence is situational or systematic, and level of responsibility taken by violent partners. When violence in the relationship is happening as part of a context of systematic power and control, a type of violence termed "intimate terrorism," couple therapy is contraindicated. Fortunately, it seems that these are the minority of cases of couples presenting for therapy, whereas for a majority of these couples who deal with violence in the relationship, that violence can be conceptualized systemically as part of a context of escalating couple distress, attachment insecurity, and the resulting extreme affect dysregulation (Lafontaine & Lussier, 2005; Schneider & Brimhall, 2014).

When working in EFT with a couple where violence is a concern, the therapist talks to the partners about a set of safety procedures for them to enact if stress becomes too high in the relationship and increases the risk of abusive responses. The couple is helped to identify particular cues and events that prime this partner's insecurities and lead into the initiation of abuse, as well as key responses that prime the beginnings of trust and positive engagement. Rather than being taught to contain the rage per se, the individual is helped to interact from the level of longing and vulnerability. When partners can express a sense of helplessness and lack of control in the relationship, they often become less volatile, and engagement with them is safer. The abused partner is supported in a process of greater self-assertion and empowerment. The abused partner's reality is accepted, validated, and made vivid and tangible. The therapist helps the partners organize and articulate their hurt and anger, including the action impulse inherent in these emotions, which is to protest, and insist on each person's right to protect oneself.

Substance Abuse

The role of any potential addictive behaviors and the impact on the relationship should also be assessed. Generally, substance abuse or other addictive behaviors may be contraindications to the extent that they compromise a partner's capacity to be accessible, responsive, and engaged in the relationship. Moderate to severe substance abuse can seriously limit a partner's capacity to be cognitively or emotionally present, and all addictive behavior has a tendency to become a focus of attention that limits the ability to make the relationship a priority. The diminished presence and ability to prioritize the partner decreases emotional safety and may make progress in EFT very challenging. In the case that substance abuse or addictive behavior is an impediment to therapy, it is recommended that individual addictions counseling be completed prior to reengaging in couple work. That said, couple therapy specifically tailored to alcohol or other substance abuse can be helpful (see Chapter 25 on alcohol problems, in this volume, by McCrady, Epstein, & Holzhauer).

Infidelity

Any ongoing infidelity would also be considered a contraindication to EFT. It is true that what constitutes infidelity may be challenging to define, and there is no objective criterion. For many partners, an emotionally exclusive relationship with another person may be considered an emotional affair, whereas for others, it might not be (see also Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder). Furthermore, for some couples, it is not problematic to seek sexual experiences outside the relationship within certain security-maintaining limits. Therefore, infidelity defined as such by either partner or the norms of the couple's relationship would be considered to be problematic.

Disposition Toward Divorce

While EFT is designed for couples whose members wish to stay together and improve their relationships, not all couples enter therapy with that clarity. Some partners need the therapist's help first to clarify their needs and goals before they are ready to work toward this end or determine that they no longer want to continue with the relationship. This might include a situation in which one or both partners admit to being involved in an extramarital affair and are not sure which relationship they wish to maintain, or one in which partners in a separated couple are not sure whether they want to work toward reconciliation (see also Chapter 21 on divorce, in this volume, by Lebow).

Empirical Support

EFT is a relatively brief evidence-based treatment, with significant positive outcomes often seen in as few as 10–20 sessions (Wiebe & Johnson, 2016). There is now a sizable body of research on EFT outcomes (Lebow, Chambers, Christensen, & Johnson, 2012; studies listed on *www.iceeft.com*; see also *https://div12.org/psychological-treatments*). In brief, results indicate that 70–75% of couples see their relationships as no longer distressed at the end of EFT, and there appears to be little relapse (Halchuk et al., 2010; Wiebe, Johnson, Burgess Moser, et al., 2017). Moreover, recent meta-analyses have demonstrated strong effects for EFT (e.g., Spengler, Lee, Wiebe, & Wittenborn, 2022).

EFT is an integrative model that draws on the most current evidence-based models of emotion, attachment theory, and effective therapeutic intervention. Research developments have situated EFT at the highest level of classification as an evidence-based couple therapy as outlined by Sexton and colleagues (2011): (1) outcome research, (2) evidence for specific clinical change mechanisms (process research), and (3) contextual efficacy including studies with a variety of couples and across different contexts.

Research examining the moment-to-moment processes in EFT and mapping the steps and interventions involved in key therapeutic events has grown, particularly in outlining the steps of withdrawer reengagement (Lee et al., 2017), facilitating the pursuer–softening event through therapist presence (Furrow et al., 2012). Session-by-session change in attachment has been demonstrated, with particular ties drawn between the softening event and immediate changes, followed by more rapid improvements in attachment and relationship satisfaction (Burgess Moser et al., 2016, 2018). New studies have also provided preliminary support for somatically focused EFT interventions that focus on bringing awareness to how emotions are experienced in the body. These interventions may enable therapists to help couples deepen their emotional experiencing, particularly for more withdrawn partners (Kailanko, Wiebe, Tasca, & Laitila, 2021; Kailanko, Wiebe, Tasca, Laitila, & Allan, 2021). These developments in process research have deepened theoretical precision and expanded clinical applications regarding the essential ingredients of moment-to-moment processes of change within sessions and over the course of EFT. One good example of this is the development of the "Tango" as a heuristic for moment-to-moment therapeutic direction in session. A second example is the strong emphasis in EFT practice on deepening emotional experience as encapsulated in the Experiencing Scale (Klein et al., 1969), which has been examined extensively in EFT process research and found to be a strong consistent ingredient of change.

An accessible group program, Hold Me Tight (HMT), that guides couples through the essential steps of secure connection, following the steps and principles of EFT, has also been developed and empirically examined. The HMT program has shown promising results in initial pilot studies (Conradi, Dingemanse, Noordhof, Finkenauer, & Kamphuis, 2018; Kennedy, Johnson, Wiebe, Willett, & Tasca, 2019) and has been a strong part of expanding the accessibility of EFT to a wider range of couples as well as international contexts, such as in South Africa, where important implementation evaluation is ongoing (Lesch, de Bruin, & Anderson, 2018).

BECOMING AN EFT THERAPIST

New and developing EFT therapists face a number of challenges whether they have been in the field for some time or are newly graduated from a training program intended to prepare one for clinical practice. Previous exposure to a systemic orientation offered by programs with an emphasis in couple and family therapy, for example, helps with the conceptualizing and integrating the individual and the system, the "within" and the "between" dimensions of couple relationships. For those with no or little exposure to a systemic orientation, adjusting to conceptualizing the challenges in relationships as co-created and maintained will be a challenge. Some may struggle with the experiential orientation of EFT, which requires a therapist to lead and follow the couple, to track closely and work on the leading edge of their experience. Many couple therapists also struggle to foster not only new behaviors but also new meaning shifts (Allan, Ungar, & Eatough, 2017). However, the EFT therapist assumes that a partner's emotional engagement with inner experience and with the other partner is necessary to render new responses and new perspectives powerful enough to impact the complex drama of relationship distress.

The therapist new to EFT (TNEFT) has to learn to stay focused on and to trust emotion, even when the partner does not (Palmer & Johnson, 2002). Our experience has been that partners do not disintegrate or lose control when they access the emotional experience in the safety of the therapy session, but TNEFTs may, in their own anxiety, dampen key emotional experiences or avoid them altogether. TNEFTs are reassured when given techniques such as grounding to enable them to help partners (e.g., trauma survivors) regulate their emotions in therapy on the rare occasions that this becomes necessary. In the same way, TNEFTs who are distrustful of attachment needs may find themselves subtly criticizing a partner's fragility. The cultural myths around attachment are that "needy" people have to "grow up," and that indulging their neediness will elicit a never-ending list of demands. On the contrary, it seems that when attachment needs and anxieties are denied or invalidated, they become distorted and exaggerated. Supervision or peer support groups that provide a safe base can help such therapists explore their own perspectives on emotional experience and on attachment needs and desires.

The TNEFT also has to learn not to get lost in pragmatic issues and the content of interactions, but to focus instead on the process of interaction and how inner experience evolves in that interaction, and how each person's context impacts those interactions (e.g., see Nightingale et al., 2019). The therapist has to stay with the partners and their lived experience rather than the model, and not try to push partners through steps when they are not ready for them. This is a normal and developmental learning process for TNEFTs. With an initial focus on the steps and stages of EFT, TNEFTs begin to organize material in a way they can make sense of and use in their clinical work (Allan et al., 2018). With practice, supervision, and support, an EFT therapist can begin to trust that new avenues open up when persisting with a partner who is unable to move or change.

For example, it is when a frightened man is able explicitly to formulate his fear of commitment, and the therapist stands beside him in that fear, that he is then able to touch and become aware of the small voice telling him that all men will leave him, just as his first love did out of fear of being discovered to be gay. As he grieves for this hurt and registers the helplessness he still feels with any man who begins to matter to him, his partner is able to comfort him. He then begins to discover that he can address his fears with his current partner, and they begin to subside.

TNEFTs may also have problems at first moving from intrapersonal to interpersonal and contextual levels. Therapists can get caught in the vagaries of inner experience and forget to use this experience to foster new steps in the dance. The purpose of expanding emotional experiences in EFT is to shape new interactions. The therapist then has to move into the "Can you tell your partner?" (move 3 of the Tango) mode on a regular basis. TNEFTs may also become caught in supporting one partner at the expense of the other. It is particularly important, for example, when one partner is moving and taking new risks, to validate the other partner's initial mistrust of this and the sense of disorientation and inability to respond immediately to this new risk-taking behavior. More experienced therapists can struggle with going back to what they already know and do in therapy (Allan et al., 2018), like well-worn grooves in their practice that are hard to move away from as they integrate EFT into their work with relationships. Despite all of these factors, research suggests that TNEFTs can use the EFT model effectively (Denton et al., 2000).

The path to competence in EFT is systematic and well trodden, and many established supervisors and training resources are available. There are more than a half dozen studies of the impact of EFT training on therapists and the process of learning EFT (all listed on *https://iceeft.com*).

CASE ILLUSTRATION

Tom and Monique, a cisgender, heterosexual couple, have been married for 7 years and have a 3-year-old girl and a 5-year-old boy. Monique is 35 years old, identifies as African American, and grew up in a middle-class family in a major urban center in the Midwest. She maintains strong connections with her family of origin, considers religion important, though not as central in their lives as it was for her growing up, and tries to ensure that her children are connected to their cousins and other family members with visits to her home city twice per year; she encourages family members to visit her whenever they can, even though it is a 12-hour drive. Tom is 38 years old, identifies as White, and grew up working class in a smaller town that is a 90-minute drive from the mid-size city where they now live. Tom is university educated, with a white-collar job now, unlike many of his family members, and he maintains connections with his family with regular visits, drop-ins, and events planned by his parents that all family members, spouses, and children are expected to attend. Like Monique, Tom grew up with religion and wants his children to be brought up with the values he learned from the church, but he is not as involved as his parents are with the church.

Monique and Tom met through a work-related networking function, and beyond the immediate attraction they experienced with each other, they quickly found a shared set of values about wanting children, centering family in their lives, understanding that both will need to work to maintain a house and life they wanted to live, and an interest in wanting to be in a mid-size city that was more affordable, diverse, and provided good work options for both of them. By the time they met, Monique had tired of dating men who were unsure about settling down with a family, while Tom felt like he had experienced enough in his dating life and was ready for the next phase and building a family.

They enjoyed dating and getting to know each other, going to concerts, sporting events, and weekend trips to a larger urban center that was 2 hours away. Early on in the relationship, they spent more time with Tom's family members because they were closer, more likely to drop in, and it seemed more convenient. Both were serious about finding someone with whom to start a family and spend their life with; they dated for 2 years before getting married in Tom's parents' backyard. Tom's family members prided themselves on being accepting of everyone, considering no one better than themselves, and themselves not better than anyone. Monique's family members were excited that she found someone who came from a family that also valued religion and hard work, and they wondered how race would be experienced in their relationship. Her older sister would sometimes pepper her with questions: "Does he have friends that are Black?"; "What was the neighborhood like where he grew up?"; "Does he know how to raise Black children?" Monique did try to discuss race with Tom, and he appeared interested and reassured her how important it was for him to love all and live by the values he was taught in the church growing up. This both reassured Monique and left a nagging feeling with her, though she told herself that with time and her encouragement he would develop a more nuanced understanding of the impact of race on people's lives.

Their early marriage and settling in with each other continued a close relationship they developed while dating, and both weathered the addition of children, with all the challenges that encompasses. Tom was a devoted father, able to pick up on and handle his share of the family and household work. Monique was a loving and caring mother; anyone could easily see how attached she was to her children and vice versa. They both appreciated the commitment they had to their family and to each other. That nagging feeling that Monique had about how Tom related to race never really left. The addition of children and the increased media attention on the impact of racism heightened her need for a partner she could trust and rely on across a variety of situations, including when she or the children might experience a racist event or the impact of hearing or reading about racist events. Their eldest child had started kindergarten and would continue to be exposed to the various behaviors from peers and the school system, not to mention the police. The nagging feeling blew up one evening while visiting Tom's family and his brother started offering excuses for the police officer who had shot an unarmed Black teenager in the major city 2 hours from Tom and Monique's home. Monique looked on in horror as his family members quietly nodded or uttered agreement as his brother spoke, and rage was added to the horror as she looked across the yard and saw Tom nodding his head as well.

She was panicked and asked him to leave immediately, making excuses about not feeling well. They packed up their children and started the 90-minute car drive home. Tom checked in with Monique on the drive home, but she was quiet, telling him she just needed to close her eyes and rest. All the while, however, Monique was contemplating what had just happened, whether she could stay in the marriage, have her children around that family, or ever feel safe with Tom again. She was caught between wanting to run as fast and far away as she could with her children and letting Tom have it for how brutally hurtful that moment was for her, and did he not think about the children!

They did not talk that night. Tom could sense something was wrong and did not say anything, hoping it would either pass or there would be an opportunity to discuss the distance he was feeling from Monique another time. The next day, they got the children ready for school and day care and went off to work. Monique was warm with the children in the morning, while Tom still felt the distance. He asked her if she slept well and she replied tersely, "Barely a wink." That evening, after putting the children to bed, Tom tried to engage Monique in conversation about her day and was met with short answers that clearly left him feeling he had done something wrong. Trying to prod her into connecting with him, Tom shrugged and joked, "What have I done now to bring on the sour puss?" Monique froze and stared at him, then in a calm, angry voice launched into how horrific the night before with his family had been. Tom defended himself and his family: "You know my brother's an idiot. We put up with his tirades; otherwise, we have to listen to him even more." Monique stayed focused, detailing how scared she was watching this White family sit and listen to someone rationalize how it was okay that a Black teenager could be shot and killed. "What if that was our son?! Would you want someone explaining away his death in that way?" Tom was struggling. Of course, he would never want anyone to talk about his son in that manner. "But you know my family, you know what they're like, they love you, they love our kids, I love you!" With tears forming in her eyes, Monique shot back, "That love was drained out of me in less than a second when I looked over and saw you nodding along to your brother."

In the days that followed, Tom kept trying to reassure Monique that his family members were good people, that he was a good person. It seemed to have little impact on Monique as she continued to be caring with the children and very distant with Tom. He oscillated between frustration ("Why do I have to pay for my brother's idiotic ideas?") and helplessness ("What can I do to make this better?") Eventually, he asked Monique if they could see a couple therapist, and she agreed, hoping that a third party could help him see the damage he could be causing their children, if nothing else.

The White couple therapist that Tom had booked broached race and other identities in their first session, with both Tom and Monique laying out the importance of identity, how it impacted their lives, and how important it was that they each felt comfortable naming their experiences in their therapy work together. Monique relaxed a little on hearing this but was still not fully trusting, though she was willing to go back. The therapist reopened the discussion about broaching during their individual sessions that took place after the first joint session. Monique shared a little about her experience with Tom's family during that individual session to explore the therapist's ability to integrate all that she wanted to discuss in couple therapy. The therapist responded with empathy, naming the experience as racism, and asking Monique how that was for her as an African American woman and mother of two Black children. She responded with one word, tears forming in her eyes, "Horrifying."

Step 2 of EFT is about identifying the negative cycle, so with this couple the therapist reflected on the pattern in their story and the moves in the interaction that they saw in front of them. Tom kept trying to defend himself and felt like he was not enough, not only for Monique but also now for children. He tried to talk about it and kept fumbling between "I'm a good person" and "I can't seem to get through to her; nothing I say matters." He focused on his responsibilities at home and his job and being a good father to his children. Tom talked a little about how he felt like Monique was "the one"—"I just felt like I am going to be with his person my whole life, no matter what." He felt "off balance" when these vulnerable feelings would emerge. In past relationships, he had dismissed these feelings and the needs that went with them. With Monique, he could not do this. The therapist discussed this pattern, in which the primal code of attachment needs and fear play out and direct the action but remain hidden, and a "spiral of separateness" takes over. This pattern could be labeled as pursue–withdraw, but Tom and Monique had their own idiosyncratic, subtle version. Tom did not even know what he was fighting about; he just somehow knew he was not enough and felt rejected. Monique remained resolute, but more emotionally wary and distant, as Tom became more upset. They both focused on their own experience in the cycle and struggled to see what the other was experiencing.

Step 3 of EFT brings each partner's underlying attachment emotions into this picture. Monique talked about wanting to feel safe at home, the one place in the world she could feel safe. "You told me when we were dating that you wanted to live by the values you learned growing up at church and I did not see those values in action that night, I just felt abandoned and scared." Tom responded, "I know, I keep trying to defend myself and my family, but I can see it makes it worse. I don't know what to say, I get lost in these discussions and feel like an idiot." The therapist picked up on this and helped Tom uncover the sadness of not being able to protect his wife and children in that moment and how inadequate it makes him feel.

As they unpack this emotional experience, with interventions such as reflection, evocative questions, and heightening, Tom continued to defend himself, while sometimes appearing angry: "I feel like I can't win here and nothing I have ever done in the past matters." Then he was sad: "I can't find a way in with you, Monique. It's like you are vacant on the inside when it comes to me." He began to understand that when he felt helpless, he had defended a working-class guy who felt he was never enough, who had to work hard to create new opportunities for himself, and who felt like Monique was someone who did believe in him. Monique said, "I don't see that, what I see is someone telling me, over and over again, 'All you can expect is to be terrified when you are around me and my family.' " She began to cry and said, "I need a partner who understands what it is like for me day in, day out in the world, and what it is like for our children day in and day out, and who wants to help them survive and maybe even thrive given all the challenges they will face! I need to know that when I go home and walk into my house that I can relax, feel that relaxation in my body, and not still be on alert." Tom leans forward and holds her.

Tom and Monique move into deescalation. Tom commits to learning more about racism and being curious with Monique about her experience and her fears for herself and their children. Monique knows she can rely on him to follow through on commitments he makes, he always has, though she wonders how he will integrate and make sense of the information he is exploring. They are able to integrate their sense of relationship patterns and underlying emotions, and to see these patterns as the problem that prevented them from being open and responsive to each other, and that set up the crisis of the attachment injury that night with Tom's family. However, they still need to create new levels of accessibility and responsiveness, and to heal the pain.

In Stage 2, the more habitually withdrawn partner usually goes one step ahead, so that this person becomes reasonably accessible before the other, more pursuing partner is encouraged to risk asking for attachment needs to be met. Both Tom and Monique withdraw at times. Tom pushes for contact but then, when disappointed, feels helpless, shuts down, and pretends for a while that everything is okay before getting openly frustrated again. Monique is very eager to feel safe with Tom and to be close to him, but when she picks up negative cues from him, she habitually goes into her shell, dismissing his concerns and protecting herself. The therapist then begins the Stage 2 process by encouraging Monique to explore her attachment fears and needs more deliberately.

A summary of one of the key moments and interventions in Stage 2 of EFT follows in the next section.

Unpacking and Deepening Monique's Emotions as Part of Withdrawer Reengagement

Monique is unsure whether she can ever trust Tom in the ways that she wants to with a life partner. There is something familiar for her about keeping him at a distance, safety in knowing that if she does not let him in too much, he cannot hurt her as much. "Maybe I am just admitting to myself what I had been wondering all along," Monique notes. "He's never really showed me how he understands the impact of racism and I just kept telling myself, he'll get it . . . how can he not get it being around me and the children . . . " She trails off, as if in her own thoughts. The therapist picks up on the moment of loss, fear, and wondering whether Tom can get it.

THERAPIST: What is happening for you right now, Monique, as you talk about whether Tom, your husband, the father of your children, can ever truly get you, know you, make you feel like he can be a safe place in the world for you?

MONIQUE: I am knotted up inside, a million thoughts racing through my head. I keep going back to that night and looking across the backyard and seeing his head nod. It was like a horror movie where I was frozen for a moment, then all I wanted to do was get away as fast as I could.

THERAPIST: Horror, frozen, and, thank goodness, you could get away in that moment. That sounded like an awful, horrible event!

TOM: Yes, I am realizing just how much my complicity in that moment had to be scary for her. I really want to find ways for Monique to see me as someone she can rely on in those moments, all the time.

Therapist: That is great, Tom. What happens for you when you hear that, Monique?

Monique: It's nice . . .

Therapist: And?

Monique: And I just don't trust it. Why would I? It's too painful to go back to that place again. I feel like he's more interested in defending himself or his family and not his wife and children!

Therapist: I am glad you have that protection, Monique. You need it, you need it to survive in the world, you need it to manage at work, and you need to teach your children to understand how to protect themselves and when.

Monique: Thanks, I don't know if Tom sees that.

Tom: I am beginning to. I never thought about it like that, that protection is a basic survival skill. Of course, it is. I'm realizing that I need to support her in that, help my children understand how to survive in a racist world. A lot of this is new for me and I am learning . . . and I really, really want to get this.

Therapist: That is helpful, Tom. We spend our whole lives unlearning racism and learning how to support the people we love. Racism pervades every aspect of our lives, and it requires someone who really, really wants to get it.

Tom: That's me. I might not be the brightest or the fastest, but I am in this for life. I want to be in it for life with you, Monique. (*Reaches for her hand.*)

Monique: I don't know if I can trust that . . . now or ever. Do you really want to hear about all the things that I encounter every day that make me question myself, how I look, or what other people are thinking?

Therapist: Tom, can you hear your wife? What happens to you when she says this?

Tom: I start to feel a little helpless, then tell myself, "I think I have often felt that way, small town working-class guy," but with Monique that's my privilege, I get to feel helpless and Monique does not ever get to turn off the racism she experiences. (*Turns to Monique.*) I have left you alone with all of that for far too long. I can't anymore, I can't not wonder every time I see something on the news how that impacts you. I can't stop thinking about our children and what I need to learn as their father to help them navigate in the world as they grow up. I can't stop thinking about all the ways I needed to respond differently that night in my parents' backyard and all the things I need to say to my family before we spend time with them again . . .

Monique: If!

Tom: You're right, *if* we spend time with them again.

Therapist: That was beautiful Tom. You seem so solid in wanting to be different with Monique and your children, and I am curious what that is like for you, Monique, when Tom talks about all the ways he does want to be a safe place for you, a person you can trust, a place that you can relax into?

Monique: This is different. I know him, I know that tone of his voice, the calm seriousness that I have learned is a place where he is determined and will commit all he can to accomplish that. I still have doubts though . . .

Therapist: Of course, you do. Those doubts tell you to be careful, this is too important. I am curious, are the doubts also saying this guy, this relationship is too important, it has to be right before I will trust again?

Monique: I guess . . . he does matter to me. (*turning to Tom, eyes filled with tears*) This isn't going to be easy. I don't know if you know what you don't know yet, how much I want you to get, how important it is for you to have a deep understanding of my worries . . . my fears . . . how much I need to be able to just basically feel safe with you no matter what.

As Monique becomes more engaged and begins to articulate her long-standing fears, Tom is also able to explore his emotions and begin to integrate new understandings he is developing about what it means to be African American. He adds work with an African American individual therapist, who coaches him and provides space for him to unpack his own racist beliefs and understandings. Monique is more and more able to order and articulate her experience, then to demand that they now deal more openly with the trauma of that night with Tom's family, so that she can begin to feel safe with Tom again. Tom is more able to engage actively in the steps for the forgiveness of attachment injuries, now that he has access to his underlying emotions.

CONCLUDING COMMENTS

EFT is an integrative, attachment-based approach to couple therapy that effectively guides couples through a structured process toward establishing a stronger emotional bond and building the foundation of a secure attachment relationship. EFT has shown strong empirical results in terms of the process and outcomes of therapy and is increasingly found to be helpful for couples facing a variety of personal challenges, including depression and PTSD. EFT is continuing to evolve in research and practice in its capacity to reach and respond to diverse couples and is well positioned to attune to the individual uniqueness of couples grounded in the universal need for love, support, and security in relationships that we all seek.

SUGGESTIONS FOR FURTHER STUDY

International Centre for Excellence in EFT: Research: *https://iceeft.com/eft-research-2*.

Johnson, S. M. (2008). *Hold me tight: Conversations for a lifetime of love*. New York: Little, Brown.

Johnson, S. M. (2019). *Attachment theory in practice*. New York: Guilford Press.

Johnson, S. M. (2020). *The practice of emotionally focused marital therapy: Creating connection* (3rd ed.). New York: Brunner/Routledge.

Kallos-Lilly, V., & Fitzgerald, J. (2014). *An emotionally focused workbook for couples: The two of us*. New York: Brunner/Routledge.

REFERENCES

Allan, R., & Johnson, S. M. (2017). Conceptual and application issues: Emotionally focused therapy with gay male couples. *Journal of Couple and Relationship Therapy, 16,* 286–305.

Allan, R., Ungar, M., & Eatough, V. (2017). "Now I know the terrain": Phenomenological exploration of CFTs learning an evidence-based practice. *Contemporary Family Therapy*, *40*(2), 164–175.

Allan, R., & Westhaver, A. (2018). Attachment theory and gay male relationships: A scoping review. *Journal of GLBT Family Studies*, *14*(4), 295–316.

Barazzone, N., Santos, I., McGowan, J., & Donaghay-Spire, E. (2019). The links between adult attachment and post-traumatic stress: A systematic review. *Psychology and Psychotherapy: Theory, Research and Practice, 92,* 131–147.

Basham, K. (2008). Homecoming as safe haven or the new front: Attachment and detachment in military couples. *Journal of Clinical Social Work, 36*, 83–96.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bradley, B., & Furrow, J. (2004). Towards a minitheory of the blamer softening event. *Journal of Marital and Family Therapy, 30,* 233–246.

Brubacher, L. L., & Wiebe, S. A. (2019). Process–research to practice in emotionally focused couple therapy: A map for reflective practice. *Journal of Family Psychotherapy, 30,* 292–313.

Burgess Moser, M., Dalgleish, T. L., Johnson, S. M., Lafontaine, M., Wiebe, S. A., & Tasca, G. (2016). Changes in relationship-specific romantic attachment in emotionally focused couple therapy. *Journal of Marital and Family Therapy, 42,* 231–245.

Burgess Moser, M., Dalgleish, T. L., Johnson, S. M., Wiebe, S. A., & Tasca, G. (2018). The impact of blamer-softening on romantic attachment in emotionally focused couples therapy. *Journal of Marital and Family Therapy, 44,* 640–664.

Cloutier, P. F., Manion, I. G., Walker, J. G., & Johnson, S. M. (2002). Emotionally focused interventions for couples with chronically ill children: A 2-year follow-up. *Journal of Marital and Family Therapy, 28,* 391–398.

Coan, J. A., Beckes, L., Gonzalez, M. Z., Maresh, E. L., Brown, C. L., & Hasselmo, K. (2017). Relationship status and perceived support in the social regulation of neural responses to threat. *Social Cognitive and Affective Neuroscience, 12,* 1574–1583.

Conradi, H. J., Dingemanse, P., Noordhof, A., Finkenauer, C., & Kamphuis, J. H. (2018). Effectiveness of the "Hold me Tight" Relationship Enhancement Program in a self-referred and a clinician-referred sample: An emotionally focused couples therapy-based approach. *Family Process, 57,* 613–628.

Cook, S. H., & Calebs, B. J. (2016). The integrated attachment and sexual minority stress model: Understanding the role of adult attachment in the health and well-being of sexual minority men. *Behavioral Medicine, 42,* 164–173.

Cortés-García, Takkouche, B., Rodriguez-Cano, R., & Senra, C. (2020). Mediational mechanisms involved in the relation between attachment insecurity and depression: A meta-analysis. *Journal of Affective Disorders*, *277*, 706–726.

Dalgleish, T. L., Johnson, S. M., Moser, M. B., Lafontaine, M.-F., Wiebe, S. A., & Tasca, G. A. (2015). Predicting change in marital satisfaction throughout emotionally focused couple therapy. *Journal of Marital and Family Therapy, 41,* 276–291.

Dalgleish, T. L., Johnson, S. M., Moser, M. B., Wiebe, S. A., & Tasca, G. A. (2015). Predicting key change events in emotionally focused couple therapy. *Journal of Marital and Family Therapy, 41,* 260–275.

Dalton, E. J., Greenman, P. S., Classen, C. C., &

Johnson, S. M. (2013). Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice, 2,* 209–221.

Denton, W. H., Burleson, B. R., Clark, T. E., Rodriguez, C. P., & Hobbs, B. V. (2000). A randomized trial of emotion-focused therapy for couples in a training clinic. *Journal of Marital and Family Therapy, 26,* 65–78.

Denton, W. H., Wittenborn, A. K., & Golden, R. N. (2012). Augmenting antidepressant medication treatment of depressed women with emotionally focused therapy for couples: A randomized pilot study. *Journal of Marital and Family Therapy, 38,* 23–38.

Dessaulles, A., Johnson, S. M., & Denton, W. H. (2003). Emotion-focused therapy for couples in the treatment of depression: A pilot study. *American Journal of Family Therapy, 31,* 345–353.

Franz, C. E., Lyons, M. J., Spoon, K. M., Hauger, R. L., Jacobson, K. C., Lohr, J. B., . . . Kremen, W. S. (2014). Post-traumatic stress symptoms and adult attachment: A 24-year longitudinal study. *American Journal of Geriatric Psychiatry, 22,* 1603–1612.

Furrow, J. L., Edwards, S. A., Choi, Y., & Bradley, B. (2012). Therapist presence in emotionally focused couple therapy blamer softening events: Promoting change through emotional experience. *Journal of Marital and Family Therapy, 38,* 39–49.

Gordon-Walker, J., Johnson, S., Manion, I., & Cloutier, P. (1996). An emotionally focused marital intervention for couples with chronically ill children. *Journal of Consulting and Clinical Psychology, 64*(5), 1029–1036.

Gottman, J. M., & Driver, J. L. (2005). Dysfunctional marital conflict and everyday marital interaction. *Journal of Divorce and Remarriage, 43*(3–4), 63–77.

Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships: Mathematical modeling of conflict interaction. *Journal of Homosexuality, 45*(1), 65–91.

Haddock, S., Schindler Zimmerman, T., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy, 26,* 153–170.

Halchuk, R. E., Makinen, J. A., & Johnson, S. M. (2010). Resolving attachment injuries in couples using emotionally focused therapy: A three-year follow-up. *Journal of Couple and Relationship Therapy, 9,* 31–47.

Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds.* New York: Guilford Press.

Johnson, S. M. (2020). *The practice of emotionally focused marital therapy: Creating connection* (3rd ed.). New York: Brunner/Routledge.

Johnson, S. M., Bradley, B., Furrow, J., Lee, A., Palmer, G., Tilley, D., & Woolley, S. (2005). *Becoming an emotionally focused therapist.* New York: Brunner/Routledge.

Kailanko, S., Wiebe, S. A., Tasca, G. A., & Laitila, A. A. (2021). Impact of repeating somatic cues on the depth of experiencing for withdrawers and pursuers in emotionally focused couple therapy. *Journal of Marital and Family Therapy.* [Epub ahead of print]

Kailanko, S., Wiebe, S. A., Tasca, G. A., Laitila, A. A., & Allan, R. (2021). Somatic experience of emotion in emotionally focused couple therapy: Experienced trainer therapists' views and experiences. *Journal of Marital and Family Therapy.* [Epub ahead of print]

Kallos-Lilly, V., & Fitzgerald, J. (2014). *An emotionally focused workbook for couples: The two of us.* New York: Brunner/Routledge.

Karakurt, G., & Keiley, M. (2009). Integration of a cultural lens with emotionally focused therapy. *Journal of Couple & Relationship Therapy, 8,* 4–14.

Kennedy, N., Johnson, S. M., Wiebe, S. A., Willett, J. B., & Tasca, G. A. (2019). Conversations for connection: An outcome assessment of the Hold Me Tight Relationship Education Program, and recommendations for improving future research methodology in relationship education. *Journal of Marital and Family Therapy, 45,* 431–446.

Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research and training manual.* Madison: University of Wisconsin Extension Bureau of Audiovisual Instruction.

Lafontaine, M.-F., & Lussier, Y. (2005). Does anger towards the partner mediate and moderate the link between romantic attachment and intimate violence? *Journal of Family Violence, 20,* 349–361.

Lebow, J., Chambers, A., Christensen, A., & Johnson, S. M. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy, 38,* 145–168.

Lee, N. A., Spengler, P. M., Mitchell, A. M., Spengler, E. S., & Spiker, D. A. (2017). Facilitating withdrawer re-engagement in emotionally focused couple therapy: A modified task analysis. *Couple and Family Psychology: Research and Practice, 6,* 205–225.

Lesch, E., de Bruin, K., & Anderson, C. (2018). A pilot implementation of the emotionally focused couple therapy group psychoeducation program in a South African setting. *Journal of Couple and Relationship Therapy, 17*(4), 313–337.

Linhof, A. Y., & Allan, R. (2019). A narrative expansion of emotionally focused therapy with intercultural couples. *Family Journal, 27,* 44–49.

Liu, T., & Wittenborn, A. (2011). Emotionally focused therapy with culturally diverse couples.

In J. Furrow, S. M. Johnson, & B., Bradley (Eds.), *The emotionally focused casebook: New directions in treating couples* (pp. 295–316). New York: Routledge.

MacIntosh, H. B., & Johnson, S. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy, 34,* 298–315.

Makinen, J. A., & Johnson, S. M. (2006). Resolving attachment injuries in couples using emotionally focused therapy: Steps toward forgiveness and reconciliation. *Journal of Consulting and Clinical Psychology, 74,* 1055–1064.

McLean, L. M., Walton, T., Rodin, G., Esplen, M. J., & Jones, J. M. (2013). A couple-based intervention for patients and caregivers facing end-stage cancer: Outcomes of a randomized controlled trial. *Psycho-Oncology, 22,* 28–38.

Mikulincer, M., & Shaver, P. R. (2016). *Attachment in adulthood: Structure, dynamics, and change* (2nd ed.). New York: Guilford Press.

Nightingale, M., Awosan, C. I., & Stavrianopoulos, K. (2019). Emotionally focused therapy: A culturally sensitive approach for African American heterosexual couples. *Journal of Family Psychotherapy, 30,* 221–244.

Palmer, G., & Johnson, S. M. (2002). Becoming an emotionally focused couple therapist. *Journal of Couple and Relationship Therapy, 1,* 1–20.

Schneider, C., & Brimhall, A. S. (2014). From scared to repaired: Using an attachment-based perspective to understand situational couple violence. *Journal of Marital and Family Therapy*, *40*(3), 367–379.

Sexton, T., Gordon, K. C., Gurman, A., Lebow, J., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. *Family Process, 50,* 377–392.

Spengler, P. M., Lee, N., Wiebe, S. A., & Wittenborn, A. K. (2022). *A comprehensive meta-analysis on the efficacy of emotionally focused couple therapy.* Manuscript submitted for publication.

Weissman, N., Batten, S. V., Rheem, K. D., Wiebe, S. A., Pasillas, R. M., Potts, W., . . . Dixon, L. B. (2018). The effectiveness of emotionally focused couples therapy with veterans with PTSD: A pilot study. *Journal of Couple and Relationship Therapy, 17,* 25–41.

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples (EFT). *Family Process, 55,* 390–407.

Wiebe, S. A., Johnson, S. M., Burgess Moser, M., Dalgleish, T. L., Lafontaine, M., & Tasca, G. (2017). Two-year follow-up outcomes in emotionally focused couple therapy. *Journal of Marital and Family Therapy, 43*(2), 277–244.

Wiebe, S. A., Johnson, S. M., Moser, M. B., Dalgleish, T. L., & Tasca, G. A. (2017). Predicting follow-up outcomes in emotionally focused couple therapy: The role of change in trust, relationship-specific attachment, and emotional engagement. *Journal of Marital and Family Therapy, 43,* 213–226.

Wittenborn, A. K., Liu, T., Ridenour, T. A., Lachmar, E. M., Mitchell, E. A., & Seedall, R. B. (2019). Randomized controlled trial of emotionally focused couple therapy compared to treatment as usual for depression: Outcomes and mechanisms of change. *Journal of Marital and Family Therapy, 45,* 395–409.

Zuccarini, D., Johnson, S. M., Dalgleish, T. L., & Makinen, J. A. (2013). Forgiveness and reconciliation in emotionally focused therapy for couples: The client change process and therapist interventions. *Journal of Marital and Family Therapy, 39,* 148–162.

Zuccarini, D., & Karos, L. (2011). Emotionally focused therapy for gay and lesbian couples: Strong identities, strong bonds. In J. L. Furrow, S. M. Johnson, & B. A. Bradley (Eds.), *The emotionally focused casebook: New directions in treating couples* (p. 317–342). New York: Routledge.

CHAPTER 7

Object Relations Couple Therapy

Judith P. Siegel

BACKGROUND

The theory that informs object relations couple treatment is voluminous and rich. Much of it has been generated by scholars whose vocabulary and assumptions may not be easily understood by those who lack analytic training. As a result, some of the most astute observations of human behavior and intimate relationships are too often overlooked.

Object relations theory emerged as a response to the limitations of Freudian concepts to explain the complexity of child development in a relational context. Through exploring mother–child interactions, these pioneering analysts constructed theories of psychic development and articulated how the child's relationship with the mother (the primary object) influenced psychological health. This chapter focuses on the application of American object relations theories to couples.

One basic premise of the object relations approach is that core aspects of the self are formed through early relational experiences. The child's identity, self-esteem, and ability to trust develop through interpersonal interactions and influence many aspects of intimacy over a lifetime. Object relations theory suggests that the choice of partner, style of managing conflict, and ability to express needs, expose vulnerability, and receive and provide nurturing are, to varying degrees, products of early family relationships. This model does not assume that lessons learned from childhood are immutable or set in stone, but rather that their influence cannot be adequately challenged until the vestiges and residues are identified and understood.

Sandler and Rosenblatt (1962) coined the term "representational world" to describe how experiences of self in relation to objects (caregivers) are retained in a psychic structure. The emotions entwined in the event are embedded within the representational world and contribute to different aspects of self and others. Even when relational memories have faded, their power to influence thoughts, feelings, and behavior is robust. The content of this internal reference system guides expectations and tacit beliefs, as well as moods and responses to daily life. Often the lessons learned in childhood are replayed in adulthood, particularly in close relationships.

Influential Object Relations Theorists

Three object relations theoreticians had a particularly strong influence on those who worked with couples: Otto Kernberg, Heinz Kohut, and Margaret Mahler. Although their theories focused on individual development and psychopathology, each framed psychic growth within a relational context. Guided by their insights, analytically inclined couple therapists expanded their perspectives and noted how childhood experiences were often repeated in their clients' couple relationships. Responses and sensitivities that were difficult to comprehend in the moment made absolute sense when viewed as "unfinished business" from the past. Although their theories focused on different aspects of couple dynamics, the earliest contributors to object relations couple theory shared an appreciation of the relational past, recognition of reenactment, and the use of attunement and interpretation to help build healthier ways of relating.

Kernberg (and Jacobson)

Kernberg's approach to therapy incorporated the theoretical contributions of Edith Jacobson (1964) and highlighted the importance of splitting in creating "all-good" and "all-bad" states that influenced cognitive functions and behavior (Kernberg, 1985). Jacobson (1964) suggested that the developing child retains memories of blissful contentment in an "all-good" area of the representational world and keeps experiences fraught with anxiety or distress in a distinctly separate "all-bad" area. As the child matures, the good and bad aspects of objects, as well as the good and bad aspects of the self, eventually merge and coalesce. Early object relations theorists suggested that the defense mechanism of splitting initially serves a useful function but is ultimately replaced in normal development by more mature defenses that allow for a merger of polarized aspects, and the creation of "good enough" representations. Children whose nurturing needs are not met in consistent ways, however, accumulate an excess of bad representations that lead to a perpetuation of splitting in order to ensure that the meager "all-good" resources remain protected.

Kernberg (1985) described two variations of impaired object relations in adults who retain splitting in the representational world, and consequently never achieve a full repertoire of mature defenses. The "borderline" structure results from a separation of the aggressive/bad aspects of self and objects from the libidinal/good representations. Because there are more experiences of being deprived or hurt by the object, the sense of being loved and of having loving objects can be easily overshadowed. By splitting the representational world into two spheres, the representations of good self and good objects are protected from the field of representations that hold aggression and disappointment.

The lack of good object representations also leads to a perpetual search for the ultimate "all-good" object who can supplement internal deficits. People with the potential to fulfill this yearning are idealized and avidly pursued. If the sought-after object refuses to be possessed, or fails to live up to expectations, however, the object is spurned and suddenly viewed as being worthless. Denial and projection serve to maintain the polarized positions as aspects of the object that do not support the chosen perspective are overlooked. Interpersonal relationships are intense and unstable, with the borderline client often forming an addictive possessiveness of the beloved object and demonstrating intense abandonment anxiety.

A second psychic structure that maintained distinctly separate representations was defined as the "narcissistic" structure. The best aspects of self and objects are contained in a grandiose unit, while the devalued aspects of self and others are split off and contained in a separate area. Activation of the grandiose sphere is accompanied by entitlement and a sense of superiority. However, criticism or lack of validation can lead to self-loathing. Lovers and children are often viewed as extensions of the self and are blamed or devalued if they fail to live up to expectations. Despite an aura of independence and superiority, the narcissist is actually dependent on external validation, and, at the same time, fearful of being controlled. Typical interpersonal problems include rapid reversals in well-being, difficulties with trust, and a tendency toward narcissistic rage and blame. It should be noted that this theory underlies the description of narcissistic and borderline personality disorders that have persisted in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text revision; American Psychiatric Association, 2022) over the past 50 years.

Couple Therapists Influenced by Kernberg and Jacobson

As family therapy emerged as a viable treatment method, several analytically trained therapists began to focus on the relationships of clients with borderline or narcissistic structures. The choice of partner and the themes that prevented satisfying intimacy were viewed as repetition or reaction to childhood experiences. Barnett (1971) and Lansky (1981) noted the extent of power struggles, blaming, and reactivity to criticism in couples with narcissistic vulnerability. Koch and Ingram (1985) highlighted the chaotic shifts between threats to dissolve the relationship, panic at the threat of loss, and reversal to dependency in relationships in which one or both partners had borderline tendencies. Horowitz (1977) was interested in the cognitive aspects of splitting, and the kinds of relationship problems that develop from different perceptions and memories of shared events. Other couple therapists explored the dynamics of couples in which one partner has narcissistic traits, while the other has borderline tendencies. Rather than focusing on individual characteristics, the therapists recognized how dependency needs and vulnerabilities created predictable relationship distress (Nelsen, 1995; Schwoeri & Schwoeri, 1981). Although some argued against the notion of diagnosing couples and focusing on pathology, these early object relations couple therapists had found relevant ways of understanding key dynamics that were prevalent among couples with volatile relationships that tended not to respond to generic systems interventions and quite often dropped out of treatment prematurely.

Kohut

Kohut's observations of psychic development emphasized the child's use of the object (caregiver) to acquire basic psychological functions. Kohut (1971) suggested that because the object was regarded as serving the needs of the child, it was related to as an extension of the self, and accordingly defined as a "self-object." According to Kohut, a child was only able to acquire a sense of personal value or self-esteem through the regard provided by the caregiver. In a similar fashion, a child could easily be overcome by anxiety, and might depend entirely on the self-object to provide soothing and comfort. The child also acquired from the relationship with the self-object a sense of twinship or shared likeness. Kohut believed that many of the psychological problems in adults who sought therapy could be traced to early disappointments and failures to receive these resources.

Couple Therapists Influenced by Kohut

Couple therapists who were influenced by Kohut's theories emphasized how lovers looked to each other to provide soothing, esteem, and twinship functions. From Singer-Magdoff's (1990) perspective, individuals who lacked sufficient empathy from childhood caregivers continued their quest for unconditional affirmation from their adult objects. Solomon (1985) suggested that conflict is often a charged reaction to the partner's failure to provide desired soothing and validation. Livingston (1995) highlighted the importance of empathy as a healing agent that the therapist as well as partners could provide. He suggested that children who had been slighted or disappointed by their objects suffered additional pain when their protests were dismissed by objects who lacked empathy. Partners who could be coached to respond to each other with attunement could learn to resolve relationship injuries and improve the potential for intimacy. As a group, these therapists focused less on pathology than on the healing power of the empathy and affirmation that were provided from adequate self-object responses.

Mahler

Other important contributions to object relations theory were made by Margaret Mahler and her colleagues (Mahler, 1975; McDevitt & Mahler, 1986). Mahler was fascinated by the young child's relational development during the first 5 years of life and suggested that the child passes through a series of stages involving separation and individuation. From an initial stage of symbiosis, the child "hatched" as a being who needs to balance independence/self-agency with dependence on the object. At each stage of separation and individuation, the object's response could help or obscure a successful resolution. Children who resolved these stages successfully achieved object constancy, which established their ability to self-soothe, trust others appropriately, and use a full range of ego functions to negotiate the world. Similar to Jacobson, Mahler noted that success was determined by the ability to merge the idealized with the devalued, so that both the self and the object were accepted as being imperfect but "good enough."

Couple Therapists Influenced by Mahler

Therapists such as Meissner (1978, 1982) and Slipp (1984) noted the relational dynamics of couples that maintained a symbiotic collusion, and the ways that aspects of self and other were invariably confused. Sharpe (1981) emphasized the consequences of blurred boundaries and dependency, and the ways this created obstacles to intimacy.

Collectively, the theoretical contributions of the early object relations couple therapists conceptualized the ways that beliefs, expectations, and defenses developed in childhood sprang to life in adult intimacy. Through recognizing these patterns and facilitating different ways of relating, couples could be helped to repair earlier injuries, curtail unrealistic relationship expectations, and create more satisfying ways of getting responses to their needs.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

Healthy Couples

Although the vocabulary that defines the vision of a healthy couple varies among the different subgroups of object relations couple therapists, all share the belief that each partner's psychic maturity contributes to the success of an intimate relationship. In intimacy, partners hope for the affirmation, care, and celebration that they longed for in childhood. This is not viewed as pathology, but rather as the nature of the relational context that is necessary for individuals of all ages to thrive. The healthy partner, however, has acquired a sense of personal security and self-esteem that allows for successful negotiation of the tasks of daily life. Individuals who have experienced a "good enough" childhood can appreciate that their "significant others" have an existence beyond the purpose of serving their needs. Thus, the capacity to be contentedly alone at times, and comfortably connected to an intimate partner at other times, reflects a level of psychic maturity that promotes intimacy. Individuals who insist that they need no one and claim independence as a mature stance are viewed as hiding their fear of dependency and vulnerability with a cloak of self-sufficiency. Both the individual who clings to a partner *and* the individual who needs to control the partner through domination are viewed as managing separation anxiety in ways that may appear to be different but actually demonstrate the same underlying issue.

The ideal balance between "I" and "we" is uniquely defined in each relationship. To some extent, this is influenced by what was observed in the couple's parents' marriages (Siegel, 2000). Each family creates its own culture by incorporating beliefs and customs that are derived from the larger social context, which include ethnicity, socioeconomic status, religion, and race. The way that parents assume gender-assigned roles also affects how children view themselves and become potential relationship partners.

Children identify with both of their parents and develop tacit beliefs that include the extent to which parents respect each other, the ways that power and influence are achieved, their parents' style of negotiating and resolving differences, and the degree to which they trust and depend on each other. These acquired beliefs and expectations may not be fully conscious, but, to some extent, will influence many future aspects of intimacy (Siegel, 1992). As children get older, it is not unusual for them to disapprove of certain attributes of their parents, as well as aspects of their parents' relationship. Disapproval may lead to disavowal or disidentification, as the grown child declares the intention never to be like a parent or engage in these kinds of relationship dynamics. Ultimately, this reaction may also influence the choice of partner, as well as the view of acceptable behaviors (Siegel, 2004).

The new intimate relationship that is created by the grown child allows for repetition of certain aspects, as well as the opportunity to establish different relational dynamics. A healthy relationship is best understood as one that allows both individuals to construct the new relational bond in a way that allows each to feel secure and to reach their full potential. Members of a healthy couple are able to support each other in the creation of their own family unit. They possess the ability to work collaboratively in the shared tasks of raising children and maintaining a home. Their comfort with giving and receiving affection is mirrored in a sexual relationship that is satisfying and fulfilling to both.

Distressed Couples

Within this broad conceptualization of health or satisfaction, there are relationship patterns that are likely to create intimacy problems. The early object relations couple therapists identified the struggles of couples in which one or both partners had borderline or narcissistic structures. From a developmental perspective, this occurs when the child has not been able to achieve rapprochement, a state that allows defensive splitting to recede.

Splitting

Splitting is regarded as a normal defense mechanism that occurs in early childhood. While most individuals acquire a wider range of defenses as they mature, individuals who lack sufficiently good self and object representations retain that structure. Splitting is coupled with denial, so that the individual sees only aspects of a situation that will support the all-good or all-bad position (Siegel, 1998a, 1998b). Under the influence of splitting, the partner, the relationship and even the therapist can be viewed as being wonderful one minute and then horrible the next. When one or both individuals in a relationship use splitting in response to a perceived threat or disappointment, there can be a rapid reversal of well-being. Typically, these couples have impaired problem-solving abilities. When things are going well, partners tacitly avoid opening up areas of discussion that could break the fragile peace. When a problem can't be avoided, things quickly spiral into intense pessimism, particularly when memories of other instances infiltrate awareness. This typically is exacerbated by emotional flooding.

Flooding

When an individual experiences flooding, similar situations from the past are triggered along with the emotions that were stored in the memory. This increases the level of emotion that is experienced and typically leads to emotional dysregulation. It is as if Pandora's wish to simply open the chest enough to peek into it results in the lid flying open and all the evil in the world flying out.

Narcissistic Issues

The narcissistic self-structure involves a grandiose part and a devalued part that are separated by splitting, so that the experience of being in either is extreme. Being in the devalued part is particularly unnerving, as the individual feels painfully worthless and unlovable. In order to prevent this distressing experience, the individual seeks validation of their superiority over others. This protective veneer is easily shattered when partners devalue or criticize each other. In those moments, blaming becomes a way of ridding the "accused fault," and by locating it elsewhere, restoring the grandiose self. Narcissistic individuals are unlikely to expose their own weaknesses in therapy, but their partners won't hesitate to openly criticize them to a couple therapist, creating an emotional crisis.

Borderline Issues

The object relations perspective of the borderline structure suggests limited "good-enough" self and object representations that must be protected. As individuals feel easily overwhelmed, they pursue a new object that seems to possess all the attributes they crave. Although individuals get strength through this relationship, their expectations are unrealistic, as they expect the new object to be available to them upon request. If the new object fails to comply, the borderline individual typically experiences an abandonment crisis, and may turn against the love object, which is harshly devalued. These cycles from "all good" to "all bad" can be created by minor frustrations and unfold quickly.

The previously described relationships suffer from rapid reversals in well-being, extreme emotional reactivity, and impaired decision making, creating issues that compromise trust and security.

THE PRACTICE OF OBJECT RELATIONS COUPLE THERAPY

The Structure of the Therapy Process

Unlike the traditional analytic approach to psychotherapy, the object relations couple model is not necessarily long term. Although it is not uncommon to work with couples over a 12- or 15-month time frame, more often, a successful course of therapy can be conducted within 16 weeks. It is also not uncommon for couples to complete a successful round of treatment and return to therapy a few years later, when different issues emerge. The passage of time and unfolding life transitions may bring new challenges, triggering themes from the past that have been dormant for decades.

Conjoint versus Concurrent Sessions

Although the couple therapist should work with the members of the couple together whenever possible, specific problems and circumstances dictate when partners should be seen alone. In the assessment phase, partners who refer to an affair, abuse, or serious threats to separate or divorce should be seen in concurrent sessions that allow for a more honest discovery. (For further explication of handling these situations, see, in this volume, Chapter 17 on partner aggression by Epstein, LaTaillade, & Werlinich; Chapter 18 on infidelity by Gordon, Mitchell, Baucom, & Snyder; and Chapter 21 on divorce by Lebow.) In these situations, members of the couple are best offered individual assessment sessions in order to fully understand the problem and make an appropriate plan. Later in the therapy, the therapist may choose to see partners alone for a few sessions in order to work on a deeper level or achieve a level of honesty that might not be attained in conjoint sessions. Some partners benefit from being able to focus on aspects of their past that they are not comfortable exposing in a conjoint session. Individual sessions also allow the therapist to review incidents from prior conjoint sessions, and work toward greater tolerance and understanding of dynamics that could not be adequately explored in the conjoint format. There is, however, a risk of creating competition between the partners, as each one vies to develop a closer connection to the therapist. It is also important to establish whether all communication becomes "public domain," so that the therapist can work freely with material that was shared in privacy. Concurrent sessions should be regarded as adjunctive options with specific goals that supplement and reinforce the main focus of the couple work, which is best approached through conjoint work.

When One Partner Has a Psychiatric Disorder

It is not uncommon for one or both partners to be engaged in individual therapy that continues throughout the duration of the couple work. In some situations, one or both individuals may be on medication for a diagnosed psychiatric disorder. Occasionally, an undiagnosed disorder may be apparent to the couple therapist, who should take steps to refer that individual for evaluation and, possibly, medication and/or treatment. Problems such as bipolar disorders, adult attention-deficit/hyperactivity disorder, addictions, and posttraumatic stress disorder create relationship problems that may be protested more by the partner than by the individual with the disorder. When a therapist is treating a couple that includes a member with significant psychopathology, it is important to ascertain that partners have moved beyond the position of blaming and locating pathology in each other. Otherwise, vulnerabilities that are raised with the partner carrying the diagnosis may be viewed as a confirmation of fault.

The Role of the Therapist

A successful therapy has provided partners with the means to discover new ways of understanding and relating to each other. In order to accomplish this, heavy emphasis is placed on meaning making, as ways of interpreting and responding are examined from multiple perspectives. The therapist must be comfortable exploring emotions in order to unravel memories and associations that have not been previously understood. Insight occurs when experiences from the past are acknowledged, emotionally connected to, and more thoughtfully understood in relation to problems presented in the here and now. It is an experience that allows both the factual and emotional aspects of memory to be recognized and validated. Only then is it possible to make the association between how the past has comingled with the present in ways that complicate partners' ability to construct the relationship they seek. The therapist guides partners to be able to offer recognition and empathy to each other, and to acknowledge the mutual themes that were previously located in only one member. This level of sharing and responding creates opportunities to experience a new level of intimacy.

Creating a Safe Environment

The first role of the therapist is to create and preserve a safe environment. Partners who have not been able to understand and regulate their emotions can become easily agitated by each other's complaints or perspectives. Even partners who seem to be calmly detached and rational may be distancing from unbearable feelings. Partners may incite each other, enflame each other, and respond to each other in ways that can quickly become emotionally dangerous. Through an awareness of personal reactions to the relationship partners, as well as a sophisticated appreciation for defenses such as denial and dissociation, the therapist can detect signals of being overwhelmed (Siegel, 2012). At this point, it is important for the therapist to intervene in escalating dynamics and take control. Often this involves asking partners to speak to the therapist instead of each other, and to prevent partners from attacking each other. Hostile and provocative comments should be interrupted, labeled as indications of anger, and explored from a stance that allows for expression of pain rather than vengeful rage or counterattack. This often puts the therapist in the role of *referee*, who needs to stop partners from hostile attacks and counterattacks.

Connecting the Dots

The therapist's second role is to help the partners make sense of the dynamics that contribute to their presenting problem. This often involves understanding the systemic sequence, the meaning that has been attributed to events, and emotional responses that may not have been fully acknowledged. Rather than focusing on described behaviors or events, the therapist must slow down the narrative and search for emotionally laden aspects that seem central to the relationship tension. Often this includes taking note of splitting and projective identifications and defining their effect on the interaction. As these dynamics are explored with the couple, the therapist has assumed a role of *detective,* as well as interpreter. Being able to help partners make sense of disturbing events and find their voices to express repressed pain is a valuable part of the process. This requires the therapist to possess a sturdy emotional balance, as well as the ability to push for and sit with difficult emotions. For this reason, many object relations couple therapists have sought their own therapy and/or seek support through supervision.

The next step in this process is to help partners trace themes and emotional experiences to memories from previous relationships. The therapist provides a historical context by asking questions about similar themes in the parental relationships, or in the relationship that partners had with each parent. Partners have often not seen themselves or their relationship as replicating aspects of their relational past, and they may be either comforted or disturbed by this notion. The therapist must find a way to translate the dynamic that is observable in the room into a theme that can be conceptualized and explored in the personal past. In this way, the therapist is both *anthropologist* and *narrator* in pursuit of meaning.

Encouraging New Ways of Relating

Rather than locate the "problem" as belonging to one partner, the therapist attempts to help both partners explore the theme as it relates to their own pasts. When toxic themes can be identified as being similar and relevant to both partners, they can respond to each other with greater empathy and break the vicious cycle of blaming. The therapist's recognition of the power of the past can help partners find strength to separate past from present, to distinguish former from current objects, and to envision a future that is not necessarily a linear extension of the past. Through offering acceptance and opportunity for change, the therapist is both *healer* and *coach.*

As partners share painful aspects of their childhoods, the therapist emphasizes how postures that were established to protect against vulnerabilities can be reexamined from an adult perspective. Partners are helped to appreciate that they are no longer their relatively powerless childhood selves that often are reactivated in recurring patterns, but that they have the ability to define and present their needs to their partner in a way that is likely to succeed. There are times that expectations may be unrealistic, or that trust needs to be restored carefully, but each successful event of asking for and receiving what is needed confirms the important distinction between present and past.

The level of confrontation and scrutiny involved in this approach requires the therapist to build a strong alliance with both partners. The therapist must remain alert to the tendency for partners to seduce the therapist into taking sides, which typically includes blaming one partner. Instead, the therapist who can clarify emotional pain and offer validation builds an alliance based on understanding. The therapist is not neutral but invested in the well-being of both individuals in the room. In this way, the therapist is also *nurturer*, who can create and maintain an environment of safety and acceptance.

Assessment and Treatment Planning

As in other forms of family therapy, object relations couple therapists appreciate systemic dynamics as well as specific relational themes that reflect earlier experiences. The couple's current family life cycle stage and associated challenges are noted. Boundaries between the partners and other systems (e.g., work, extended family, and community/social networks) are also relevant to the assessment. It is also important to understand the life challenges and stressors that the partners have encountered, and the ways they have dealt with them. This informs the therapist about the context of this family's life, as well as the events that affect day-to-day functioning.

Early in the initial interview, the therapist needs to ask each partner why they are seeking therapy at this point in time. In addition to understanding the content that is generated in the answers, the therapist pays attention to the relational dynamics that are revealed. For example, the response may demonstrate a tendency to blame or unrealistic expectations. Partners' nonverbal reactions and the emotional climate in the room are noted. Although the stories that the partners tell hold valuable information, there is equally important material to assess as the therapist witnesses the partners' sensitivity to each other, attempts to protect or devalue each other, and expressions of rejection or contempt.

Any reference to extreme outbursts of anger; controlling or intimidating behavior; or abuse of alcohol or other substances, food, or sex should be noted as important concerns. The therapist should then slow down the assessment in order to get sufficient information to base a decision on whether to recommend individual concurrent sessions. Intimate partner violence, for example, is not likely to be fully revealed in a conjoint session and, if exposed, may compromise the safety of the victim. A partner who is having affairs or is intent on ending the relationship may also not share these plans in their partner's presence. Relationships in which one partner seems detached and uninterested are often on the verge of dissolution and should be screened through individual sessions that allow the therapist access to information that would probably not be otherwise revealed.

The decision to schedule individual sessions as part of a thorough assessment should be based on the therapist's suspicion that important information is being withheld. Without understanding the complete nature of the couple's situation, and each partner's motivation to work on relationship problems, meaningful treatment is impossible.

Given the importance of family history to the object relations model, it is usually relevant to ask for some information about each partner's family in the first session. This may include whether parents are still alive and in good health, the geographic locations of family members, and the quality of existing and past relationships with parents and siblings. During this conversation, differences in socioeconomic, cultural, ethnic, and/or religious backgrounds are likely to emerge. It would be timely for the therapist to inquire about the ways that these differences have surfaced in the couple's relationship, and how the partners have managed differences between themselves and their in-laws. If one partner is transgender or if the couple is same-sex, it is relevant to ask about coming out to extended family, as well as the support systems in the couple's community.

It is also important to get some basic information about the couple's past relationship experiences, such as previous marriages or other long-term relationships. The therapist may ask how long the partners knew each other before making a commitment; the qualities that attracted them to each other; and important aspects of their shared life, including geographic moves, jobs, health issues, and decisions and events surrounding pregnancies/adoption and raising children. Questions regarding affairs, separations, and previous couple therapy also yield important information.

The initial snapshot of the couple should allow the therapist to note strengths and supports, as well as areas of conflict and deficit. Although it is impossible to truly know a couple through an initial assessment, the therapist creates a sketch that will be completed in greater detail as pertinent areas emerge in the therapy. The therapist who asks each partner at the conclusion of the initial assessment interview "What haven't I asked that you think might be helpful for me to know?" often learns a great deal.

In subsequent sessions, the therapist focuses on the presenting problem and circumstances that may have preceded it. Work with the presenting problem is intended to identify the key theme or themes that have led to conflict or distancing. However, the therapist should focus on the following dynamics as they emerge in the therapy.

Splitting

Splitting is a defense mechanism that influences cognition and mood. Splitting serves to create a dominant perspective that is either "all good" or "all bad." In order to maintain that perspective, memories and events that contradict the polarized view are minimized or denied. In an episode of splitting, an individual only has access to the memories that support the polarized position. This can be likened to a two-drawer filing cabinet, in which one drawer is filled with the "all-good" memories, and the other with the "all bad." Just as a filing cabinet is designed to allow only one drawer to open at a time, splitting ensures that contradicting information is momentarily denied. Thus, under the influence of splitting, an individual may recall shared events from a very different perspective than that of the person's partner, adding to mistrust and pessimism.

Individuals who use splitting and denial in adulthood tend to see themselves and others in "all-or-nothing" terms. As a result, their relationships take on certain characteristics, including difficulty solving problems, sensitivity to criticism, control struggles, and rapid reversals in well-being (Siegel, 1992, 1998a, 1998b). Partners of those who engage in splitting often describe "walking on eggshells," as they never know when something trivial might cause a strong reaction that spirals into relationship misery. Partners who engage in splitting may attempt to avoid discussing problems in order to keep the fragile peace. Eventually, these couples run out of safe topics.

Projective Identification and Disidentification

Relational experiences are encoded in the representational world and are retained along with the original emotions. For example, a child who is repeatedly shamed by a parent for failing to live up to expectations will continue to be sensitive to the opinions of authority figures. This theme may also be reenacted in intimate relationships. The once-shamed grown child may now assume either the role of the one who worries about disappointing or the role of the authority figure who judges and disapproves of the partner. Both roles allow for a reenactment of the troubling theme, as well as the potential for resolution. Partners can locate unbearable aspects of themselves in their partners and can react to them from a distance. The early dilemma leaves vulnerability around shame and authority that can be easily sparked.

Projective identification is most simply understood as a reenactment sequence, in which unresolved themes are played out between the partners. One partner stimulates or entices the other to react in a way that allows the projective identification process to unfold. It is as if the partner is being offered a script that allows a theme from the past to be replayed in the present. The partner is now viewed in a way that merges past with present and is assigned attributes and intentions that hold true to the theme that has surfaced. In most situations, both partners will engage in the reenactment in a way that is highly reactive. Typically, the emotional pitch changes rapidly and reaches a level of intensity that may not be easily comprehended by outsiders.

Disidentification is similar in the way that past relational dynamics have led to defenses and high reactivity. However, in disidentification, the individual has vowed never to repeat offensive aspects of the past, and retreats or strongly protests when treated in a way that evokes the past.

Unrealistic Expectations

Children are easily overwhelmed by uncomfortable emotional states and rely on their caregivers to help them feel protected and secure. The parent who is able to provide consistent soothing establishes a secure attachment and the ability to trust in the good intentions of others. The child who is too often left alone with overwhelming emotions and anxiety, however, lacks the skills to manage troubling emotions. In these states, children may protest their desperation but eventually shut down in a defensive reaction. Depersonalization, isolation of affect, and dissociation are attempts to numb emotions that are too difficult to bear alone.

Children also depend on caregivers to establish their sense of importance. Self-esteem is built by parents who can joyfully appreciate their child's abilities and qualities. A child who receives more criticism than praise may develop crippling self-doubt. A child who is only praised for virtues that are defined by the parents may seal off aspects of self that are not valued and become increasingly dependent on the external world to provide reassurance and affirmation. Fear of criticism and failure can lead to vulnerability in maintaining self-esteem, and a tendency to locate failure and shame in others through blame.

In adult intimacy, the significant other is bestowed the power to provide security and esteem. When the new object fails to provide these functions or unconditional love, there is typically a strong emotional reaction—either a shutdown/implosion, or heightened emotions/explosion.

Countertransference

In addition to information that can be obtained through questions and observation, object relations therapists emphasize the use of self-awareness to understand relational dynamics. The term "countertransference" is used to explain how a therapist's personal response to the couple is regarded as a valuable form of emotional communication (Siegel, 1997). Although traditional analysts regard countertransference as revived themes from unresolved conflicts in the personal life of an analyst, the "totalistic" approach offers a different explanation. The totalistic approach suggests that the nature of the work provokes responses in the therapist that have more to do with patients' than with the analyst's unfinished business. Countertransference, then, is a conceptual umbrella allowing therapists to examine their own reactions as a form of communication that emanates from the couple (Siegel, 1995). It can be best be understood as a kind of projective identification in which the therapist is stimulated to "know" a theme that cannot be articulated but needs to be understood.

The therapist who can sense the role being stimulated to accept has immediate access to a theme that is likely being enacted between the partners. For example, a therapist who feels cross-examined or scrutinized may respond by becoming self-doubting or defensive. Once the therapist has identified the emotional response, it may be discovered that the same themes are being played out within the couple—with one partner taking the upper hand and the other waffling in doubt. The therapist may also find that the theme of superiority–inferiority is a stance that the couple plays out as a unit; the members create connection between themselves through noticing the inadequacies in peers, family members, or their therapist. Countertransference is a form of emotional communication alerting the therapist to dynamics that have not been successfully resolved or integrated but instead are reenacted in interpersonal relationships.

These dynamics create a frame of reference through which the therapist makes sense of the couple's conflicts and reactions to each other. When they surface in the sessions, they become the primary focus of attention, and lead to specific goals and strategies.

Goal Setting

The heart of the object relations approach to couple therapy involves challenging assigned meaning and facilitating new responses to old wounds. The therapist must be comfortable exploring emotions that invariably lead to awareness of memories and associations that have not been previously understood. Insight occurs when experiences from the past are acknowledged, emotionally connected to, and more thoughtfully understood in relation to the present. It is an experience that allows both the factual and emotional aspects of memory to be recognized and validated. Only then is it possible to make the association between how the past has comingled with the present in ways that complicate a partner's ability to construct the relationship they seek. The therapist guides partners to be able to offer recognition and empathy to each other, and to acknowledge the mutual themes that were often previously located in only one member. This level of sharing and responding creates opportunities to experience a new level of intimacy.

Engagement

Engaging the couple in the treatment process involves reflecting on the couple's presenting problems in a way that not only acknowledges the partners' complaints but also incorporates dynamics that have been made apparent through the therapist's observations and questions. For example, splitting and projective identifications are dynamics that affect partners on both an individual and a dyadic basis, and, when defined, can help the partners look at their relationship problem in a new way. Although most couples express relief at being understood, the dynamics that have created problems may keep partners locked into cycles of blame. This becomes particularly challenging when the blamed partner has a psychiatric diagnosis.

The early stage of treatment involves helping the couple make the transition from blame to a perspective that allows for a more complex appreciation of emotional and behavioral responses. Goals include understanding the presenting problem, but in an expanded way that recognizes specific underlying dynamics that need to be explored and addressed. Through this process, goals are constructed collaboratively between the couple and the therapist. Priority is established by the couple and is typically influenced by the events that have been most problematic to the partners at the time. Issues that are emotionally charged provide access to the most important themes and often influence the goals of the therapy.

The couple's decision to commit to treatment may reveal important aspects of the partners' capacity for intimacy. Partners with the tendency to split often express despair and hopelessness when they are in an "all-bad" state. Their pessimism may influence them to discontinue the treatment, based on their polarized view that nothing can help. It is also possible, however, that a breakthrough in the relationship can stimulate the illusion of an idealized "all-good" state, and lead to a decision to drop out of treatment in order to avoid discussing problems that might lead to revived conflict and despair. For this reason, splitting should be defined as soon as it is detected. Partners who can begin to acknowledge the thoughts and emotions that define a polarized state can learn to challenge impulsive responses and decisions, and instead to search for information that in the moment may be overshadowed.

Ambivalence is not an unusual experience for a couple in a deteriorated relationship. The hope that repair is possible is easily offset by reminders of previous failed attempts. Recognizing and validating both parts of the ambivalence often provides a holding environment where partners feel truly understood and accepted.

It is also not unusual to discover that one partner is motivated to work on the relationship in therapy, while the other protests the need for professional intervention. In the same way, one partner may be hopeful that the relationship problems can be corrected, while the other is more pessimistic and has considered ending the relationship. My response to this dilemma is to inform the couple that therapy has a potential to improve understanding and closeness, but that it involves a commitment to the process and a risk of opening up topics that may lead to conflict or expose vulnerability. I often advise couples that after four or five sessions, they will have a better understanding of the kinds of issues that need to be examined, as well as a feel for how this process works. By that point in time, they can make an informed decision. When one partner is on the verge of ending the relationship, I meet with partners alone, in individual sessions. My recommendation, however, is that if there is any doubt, there is little to lose by trying to work on the relationship for a few months. The relationship may not survive, but the reasons behind its failure will be clearer, and the dissolution may be less painful for both (see also Chapter 21 on divorce, in this volume, by Lebow).

Process and Technical Aspects of Couple Therapy

Object relations couple therapy is a model that asks the therapist to work with the emotional/intuitive parts of the self, as well as the rational/intellectual side. It is assumed that the conflicts and unresolved issues from the past that caused and continue to cause pain may not be conscious or fully understood by the partners. Therefore, the process of therapy requires creating an atmosphere of safety and curiosity that allows themes to emerge and connections to be made. The techniques used in this model are ones that help the therapist and the couple co-construct a contextual meaning for the sources and triggers of the dynamics that cause distress and prevent closeness.

While the first session involves exploring the circumstances that led to the appointment and soliciting factual information about present and past events, the therapist's demeanor and ability to establish ground rules are critical in setting the stage. A nonjudgmental attitude, genuine curiosity, and ability to relate to each partner are essential in order to establish safety. Getting to know the couple requires that attention be paid to both the content level of information and the dynamics that can be seen through nonverbal responses and levels of emotional intensity. Establishing safety is essential in this stage, and the therapist should create a contract that allows conversation to be interrupted when intense emotions have taken over. This typically involves psychoeducation to explain the importance of being emotionally centered in order to fully engage in difficult conversations, and exploration into the ways that partners have found effective in regaining emotional balance. The first time I sense that one partner is beginning to implode or explode, I interrupt and state that it seems what is being talked about is very important and I want to be sure that both the partner and I understand. In order to fully comprehend, I want us all to step back for a moment and take some deep breaths.

The case described below illustrates techniques and strategies that are frequently used from an object relations approach.

Understanding the Presenting Problem

CASE ILLUSTRATION

Steven had requested an appointment, saying that he thought his wife was having an affair and lying to him about it. Steven and Ann, a White couple in their late 30s, had been married 14 years and had three children ranging in age from 6 to 12 years. Ann had worked as an architect before the second child was born and was currently a full-time mom who did volunteer work through their church. Steven was employed in commercial real estate, and often traveled overnight for business. Ann had a small group of friends in the community that walked their dogs at the same time. On one occasion, Steven had called Ann during the day, and she said she couldn't speak and hung up. She told him she was walking the dog, but he later found out that she had stopped by her friend's house for coffee and didn't want to have to explain everything. The neighbor she had visited was a man who worked locally and whose wife was visiting out-of-town relatives, and Steven felt betrayed. Ann had lied the first three times he asked specifically where she was when he called. Based on his suspicion, he asked to search her cell phone and found a few text messages from this neighbor. Ann insisted that the neighbor was simply a friend who had been walking his dog with her and asked her to join him for a cup of coffee. When I asked how they were doing otherwise, both agreed that they had been drifting apart for years and that the romance part of their relationship was pretty dead.

After this brief discussion, I told the couple that I typically spend 15 minutes with each partner, then bring them together for the last part of the session. (Although in most situations I work primarily within conjoint sessions, I do connect with each partner separately when the presenting problem is an affair.) Although this raises issues around confidentiality, it is more important for me to know what I am dealing with. Affairs are a common presenting problem in couple therapy and need a modified treatment approach (Siegel, 2020). In my private time with Ann, she insisted that she had not had sex with her neighbor, and only communicated with him about dog walking. She said that if she had been having coffee with a female neighbor, nothing would seem unusual, and she resented Steven for not trusting her. But she also said that speaking with this man was more interesting than spending time with her husband, and that she was often lonely.

In our private discussion, Steven expressed uncertainty about believing Ann. He said that if their marriage were stronger, he probably wouldn't have gotten upset, but their sex life was almost nonexistent, and he didn't feel like she loved him anymore. He said that he had sacrificed everything for the well-being of his family and didn't deserve to be lied to. When I brought the partners together at the end of our first session, I said that the suspicion about an outside relationship was the tip of an iceberg, and that the partners had been drifting apart for years. I told Ann that Steven wanted to believe her, but that he also needed to build back trust because she had lied about her whereabouts. The couple decided that Steven should be able to check her cell phone periodically just to make sure there was no communication between Ann and their neighbor, and she agreed to only walk with the neighbor when there were others present. Given their individual loneliness, I suggested that we meet on a regular basis for six or seven sessions and see what we could do to get their relationship back on track.

Learning about the Past

Rather than starting therapy by taking an extensive detailed history, I typically ask for a rough sketch of the families of origin and the couple's early days. I focus on the quality of the relationships between each partner and their other family members, and the nature of their parents' marriages or relationships. The historical facts are less important than the relational themes, and I return to the family-of-origin information when specific areas of concern emerge in the couple work.

In the object relations approach, the ability to recognize key themes is essential. The partners' emotional responses to each other are viewed as being influenced by memories that have been stimulated, and supply meaning to unfolding events (Siegel, 2017). When the past blurs with the present, it typically adds intensity, but it can also create distortions in how the present is responded to and interpreted. In order to successfully make sense of past experiences that have resurfaced, the therapist has to know which aspects of each partner's history are most likely to be involved.

CASE ILLUSTRATION

Steven was the second child in a family of four boys. Both of his parents worked full-time, and the boys were frequently on their own. Steven described the family as being "normal" but that there was an emphasis on accomplishment. He described his brothers as being very competitive with each other, which was expressed through rough play and sarcastic put-downs. His parents were still married, but Steven described his mother as an "oddball" who didn't quite fit in. Other than celebrating occasional holidays, the extended family didn't have much contact. Steven described himself as a couch potato who liked to watch sports or movie reruns, and who made his family a priority.

Ann was the younger of two daughters whom she described as being overprotected by their parents. The family had a housekeeper who prepared all the meals and did the laundry, and Ann said that she had absolutely no idea how to do either when she left home for college. Ann noted that she had been her father's favorite, while her sister was closer to their mother, but she didn't think much about that until she had children of her own. She described herself as being much more social than Steven, and that whereas he was happy to go to the same restaurants and vacation at the same resort each year, she often felt confined and bored.

The partners had been introduced by mutual friends and felt an instant connection. Both valued hard work and achievement and were successful in their relative fields. They shared the same religion and had similar goals for the future. They agreed that things had started to deteriorate after their second child was born, and Ann quit her job in order to stay home full-time. Steven had fully supported this decision but also felt considerable pressure as the only financial provider. He had to take on extra clients and push himself to close deals in order to make the kind of commission that he needed. When I asked if he was able to share some of that with

Ann, he scoffed at the notion of needing support when it was clear what he had to do to succeed.

Incorporating Countertransference

The therapist's use of self in object relations couple therapy is an important part of the model. Although most couple therapists learn to balance attention between the process and content aspects in any session, the object relations couple therapist must also focus inwardly, in order to attend to the subtle shifts in self that may also yield important information. Processing countertransference involves being able to register the emotional response, manage the experience, and identify the feelings and impulses that have been triggered. It is also important that the therapist screen for personal issues that may have been stimulated in order to ensure that the issue at hand belongs to the couple.

Processing countertransference requires an ability to tolerate uncomfortable emotional states and hold on to a theme until its meaning can be adequately processed. At that point, the therapist can choose whether to probe for shared experiences or wait until a similar theme appears in the couple's interaction. For example, if a therapist feels disregarded or made peripheral, one option would be to ask each partner whether they are ever made to feel discounted or unimportant by the other partner. The therapist can also use this awareness to be more sensitive to this theme in the couple's interactions and pause the session to explore the dynamic when it surfaces in the couple's process. It might be said that the therapist has experienced this reaction as well in the sessions and suggest that it is relevant to the relationship. Even if the couple rejects the material that has been introduced, the therapist has demonstrated openness and a spirit of inquiry that model the processes of self-reflection and willingness to take risks. The ability to reflect and think about relationships in a new way is an important aspect of the object relations approach and is anchored in the therapist's ability to do this with him- or herself as well as with others.

CASE ILLUSTRATION

In the second session, I tried to get a better understanding of Steven and Ann's life together, and how they made decisions and co-parented. Although it is not unusual for individuals to seem uncomfortable when they start therapy, I felt that Ann was distancing herself from me. I felt like I had to pry to try to get basic information from her and that she had little interest in speaking with me.

THERAPIST: Ann, you are answering all my questions, but I get the sense that you really don't want to be here. I feel a little shut out right now.

ANN: I agreed to give this a try and I'm answering everything you ask me.

THERAPIST: Yes, you are, but I feel like there's a wall around you and you really don't want to let me in.

STEVEN: That's how I feel most of the time—like she's here, but she's not happy about it.

THERAPIST: I'm wondering if you don't think it will be safe to open up to me, or if maybe you have doubts about being in therapy?

ANN: I just don't see where this is going to take us.

THERAPIST: Ann, last week when we spoke, you shared how lonely you feel in this relationship. I suspect that you have a lot of disappointments that you're holding inside. How can I help you use these sessions? I'd really like to understand what you've been going through.

ANN: I don't think Steven is capable of being the partner I need right now in my life.

THERAPIST: Ann, what you are saying is very important, but I am surprised that you are talking in a very matter-of-fact way. Where is the sadness or the anger? I see the wall, but I'm not sure if it's there to protect you from Steven or to help you hide emotions you don't want to share.

ANN: If I complain, it's just one more thing that Steven will hold against me.

THERAPIST: I get the sense that "holding things against each other" is important and part of the reason your relationship has suffered over the years. Can we shift gears and talk about that now?

Exploring Underlying Beliefs

Once the therapist has been able to identify a theme that appears to underlie the couple's distress, it is time to untangle the pain from unresolved aspects of earlier relationships from the meaning and emotions partners assign to each other. The therapist does not minimize the hurt that partners are inflicting on each other but is able to note how the echoes from the past may be influencing the construction of meaning that has been assigned. Cozolino (2016) suggests that well before a person has conscious understanding of an event, the brain has processed the most salient memories to obtain information that is relevant for interpretation. Partners rarely stop to question whether they have interpreted the other's intent correctly and make assumptions in the construction of meaning that are not always accurate. This aspect of couple therapy has been supported by current neurobiology research. Barrett's research (2017) demonstrates how memories guide sensory input to produce a response that is tailored to the immediate situation. The language that is learned to explain emotions, as well as relationship models and concepts that predict interpersonal responses, have an enormous influence on the here and now (Siegel, 2017).

CASE ILLUSTRATION

The following excerpt provides an example of how one might explore underlying beliefs to identify unspoken, competing needs.

THERAPIST: I'd like to get a better understanding of how this has worked in your relationship. Can you describe an example of the kinds of things that either of you hold against each other? It might be a grudge that gets referred to when you are having a disagreement.

ANN: Well, it might sound silly, but the thing we probably fight about the most is the dishes. Steven often works late, and I usually have dinner with the kids. I leave Steven's dinner in the stove so it will be warm and expect that he will clean up after himself . . . but he never does.

STEVEN: That's not what happens. You leave everything in the pots and pans that you've cooked with and expect me to do all of them. You could easily do them yourself and just put my food on a dish that I could microwave.

ANN: You know by the time I've finished helping the kids with their homework and serving dinner that I'm exhausted. You eat the food I cook; you should help clean up, too.

STEVEN: You know that I do more around the house than any of your friends' husbands. But after a long day of work, you're really pushing it.

THERAPIST: When I hear couples argue like this, I think of the concept "competing needs." It's easy to be generous and giving when your own needs are being met, but when two people have the same need at the same time, it can become adversarial. It sounds to me like you're both worn out and not feeling very appreciated for what you do.

ANN: Well, Steven has no compassion for my situation.

THERAPIST: Can you tell me more about that?

ANN: I have a kind of anemia disorder. Sometimes I feel okay, but there are lots of days that I'm just exhausted. I usually feel okay for 2 or 3 weeks after my transfusion, but the next month can be hell.

THERAPIST: Transfusion?

ANN: Yes, my body doesn't absorb iron the right way. I was pretty okay until after the kids were born, but I guess it gets worse with age.

THERAPIST: Can you tell me more about the treatment? What does a transfusion involve?

ANN: Well, it's in the cancer center, so it's pretty depressing. I have to be there for 4 or 5 hours, but I try to get a friend to be there at least for a couple of hours.

THERAPIST: A friend? Does Steven ever go with you?

STEVEN: She never gives me advance notice. I plan my trips and schedule appointments at least a week ahead, but she'll spring it on me the night before, when it's impossible for me to clear my calendar.

THERAPIST: So you've never gone with her?

STEVEN: No. But I know that she gets tired, and I help out in other ways. Lots of ways.

THERAPIST: We started talking about holding a grudge, but now we're talking about asking for help. It seems the two are connected. Can we go back to before the time that Ann's condition was diagnosed? What was it like to have to ask each other for help before that?

ANN: We never had to. I've always prided myself on being very capable and independent.

STEVEN: We both are. I think that was one of the things that attracted us to each other. We were both active, successful people and very proud of each other.

THERAPIST: So neither of you had a lot of experience asking each other for help. I'd like to take a moment to look at that theme in your families when you were growing up. Steven, how did people in your family ask each other for help?

STEVEN: Are you kidding? The rule in my house was that only the strong survive. If anyone couldn't pull off what they were expected to, they were made fun of and put down.

THERAPIST: Sometimes these old memories cause us to predict that the same thing will happen in the present—just because that's what happened over and over in our past. I wonder if you have become overburdened and don't know how to get the support you need.

STEVEN: I can do what I need to—I just want to be appreciated for it.

THERAPIST: Ann, can I understand how it worked in your family?

ANN: I have never needed to ask for anything. My parents were very loving. They always supported my interests—came to all of my games and debates. If I was upset about anything, I didn't need to say a word—they just knew. My dad especially, and he always knew just how to cheer me up.

THERAPIST: So your memories tell you that if someone loves you, they know when you need something, and they know just what to do.

ANN: Exactly. If you have to ask for it, then it's not worth anything. And with Steven it's even worse because he will give me a look that says, "What? Something else you can't do now?"

THERAPIST: And when Steven leaves the dishes in the sink overnight, it's a reminder to you that he doesn't care?

ANN: Exactly.

Creating Awareness of Shared Themes

Partners choose each other for a variety of reasons, several of which have been explored from an object relations perspective. Richter (1974) suggested that a new lover could sometimes be a replacement for someone from the past who has been lost. For others, the new object can represent parts of self that are viewed proudly but cannot be validated when thought of as belonging to the self. Just as often, a chosen partner may possess negative qualities that are all too familiar, despite attempts to correct these. In most instances, partners develop a complementary posture, where aspects of the past can be stimulated for both.

The Power of the Past

Unfinished business from the family of origin often shapes partners' expectations and reactions to each other. The events that are selectively attended to and the meanings that are attached to these can be viewed as constituting a nexus between past and present. As these interactions unfold in the therapist's office, the therapist is in the unique position of participant-observer to the repetitive cycles that have contributed to the couple's problems. The earliest indicator of an unfolding projective identification sequence is an emotional shift in the couple's interaction that is perplexing to the therapist. The dialogue may suddenly take an unanticipated turn or produce responses that evoke strong emotions in one or both partners. While the therapist may be baffled or at a loss to explain the rapid, intense interaction, the couple appears to be completely familiar with the scene that is unfolding.

Often the painful themes that are being enacted are not fully understood by the partners and may even be topics that are avoided or denied. As emotionally laden memories from the past merge with the present, the interpretation of events becomes distorted and complicates effective communication. It is the therapist's job to identify and unravel these emotion-bearing issues in a way that clarifies underlying themes and emotional responses, and in so doing to create insight. From an object relations perspective, insight can only occur when emotions, and the event that triggered them, are connected to earlier events that were referenced in the creation of meaning. The therapist must capture and relate to the affective experience of each partner, and the way each has constructed and assigned meaning to the interaction. Rather than challenge a distortion or emotional overreaction, the therapist must pursue the meaning of the experience to each partner.

In helping the couple make sense of the interaction, it is useful to define the sequence as existing in the present but as echoing the past. The therapist searches for a connection between how each partner is made to feel and how the partners have felt in the past. Although partners can refer to previous examples from their own relationship, often the theme that has created the most intense reactions originated in childhood. Only through exploring the historical context of meaning can true insight occur. It is not surprising that many intense emotional reactions are colored by previous relational experiences. Children who have not been given opportunities to resolve difficult situations with their caregivers learn that their personal needs are not going to be responded to, and that voicing criticism or making demands just leads to rejection. Frequently, they have developed defenses to help them cope and prevent further disappointment. Emotions that were overwhelming in childhood may have been repressed but are encoded in memories, and surface to inform and add meaning to the present (Siegel, 2021).

The power of the past can also be seen in the way partners disidentify or take a rigidly polarized position against a specific family dynamic. Children are participant-observers of the world they inhabit and keenly aware of family relationships. They are able to notice the way parents treat each other as well as siblings and extended family members. Bandura and Walters (1963) suggested that observation may be as powerful as direct experience, as children transfer the knowledge of what happened to someone else into their own worldview and expectations. Key themes that children notice in interpersonal relationships include trust, respect, power, and ways of negotiating differences (Siegel, 2000). However, at a certain age, children are able to denounce a specific dynamic, and vow that they will never be like that, or be in a relationship that repeats what they abhor (Siegel, 2004).

While an adult is provoked into an experience of being like or being treated in a way that is similar to the disavowed theme, there is invariably a strong emotional reaction. In a way that is similar to projective identification, the unacceptable theme must be vigorously contested, often with strong emotions that seem appropriate to the individual but excessive and often uncalled for by others.

CASE ILLUSTRATION

Before the third session, Steven had told Ann that he wanted to be with her at the next transfusion, and the couple had set that date. Ann had decided to keep Steven's dinner on a plate and soak all the pots and pans she had used in preparing the family meal. There were some nights that she found it easy to finish cleaning, and other nights that Steven found it easy to clean pots that had been left to soak. We had also discussed ways to spend some relaxing time together, and the couple had agreed to watch a movie or TV show together on the nights that Steven came home early. As a result, Ann's "wall" had started to come down, and the partners felt they were heading in the right direction.

There was an apparent shift between the couple that ended their third session and the couple that walked into my office the following week. Ann seemed annoyed and distant, and once again appeared to have no interest in the session.

THERAPIST: Ann, I think I see that wall up again. Did something happen this week?

ANN: I think that the problems between us are too set in stone to change.

THERAPIST: It feels like there was an incident that has disappointed you. Can you tell me what happened?

ANN: Steven can only fake his support for so long. Our son failed a math test, and when Steven found out he blamed me for not helping him study or going over his homework like I'm supposed to do.

THERAPIST: Ann, I want us to talk about how criticism works between the two of you, but before we do that, I want to talk about something I call splitting. It explains how things can fall apart so quickly, and how awful it feels when they do.

Confronting Splitting

In many of the couples I work with, the partners tend to view each other and their relationship in "all-or-nothing" terms as a result of dyadic splitting (Siegel, 2006, 2010b). When a partner is in an "all-bad" posture, they are only able to focus on factors that confirm the devalued position and filter out any information that might contradict the prevailing perspective. Splitting adds to pessimism and creates emotional intensity that prevents thoughtful consideration or effective problem solving.

I explain that our brains store memories in areas according to the kind of emotion that was experienced at that time. In many ways, it is like a two-drawer file cabinet, with the all-good memories stored in one drawer, and the bad kept in the other. When our brains draw on a memory that can help us quickly interpret what is happening, it opens a file in the drawer that is most likely to be accurate. But when the file is opened, the emotions that were part of its contents spill into the present, making emotions more intense. At the same time, any memory that could help mitigate against this is in the other drawer, out of sight and out of mind. Explaining how splitting influences thoughts and feelings is a form of psychoeducation that most individuals are able to comprehend. Partners who fluctuate between polarized extremes are usually able to recognize this dynamic when it is pointed out to them and can acknowledge that the peaks and valleys have been exhausting and destructive.

I advise my clients that in the heat of the moment, they might not recognize that they are splitting, but that their mood and conclusions are more extreme than called for in the situation. I suggest that if they're in the "all-bad" drawer, there are other memories adding to the intensity of their emotions, and other aspects that are probably being glossed over. Standing back and taking a few deep breaths can help an individual focus on the present and be slightly less reactive.

CASE ILLUSTRATION

The following excerpt reflects how, in a subsequent session, I began to challenge Ann's tendency toward splitting.

THERAPIST: Last week, we talked about how the brain stores experiences and picks the ones that are intended to help us make sense of the situation we're in. We could see that the emotions that are still held in these memories get revived and add to our reactions. Splitting refers to how we keep memories of positive experiences in a different part of the brain than the networks that store the bad. It's really like a two-drawer file cabinet because when one drawer is open, the other drawer is shut tight. When that happens, we can only remember things that support our interpretation. So, if right now you're feeling unfairly criticized or unsupported by Steven, your brain has picked out several memories that are in the all-bad drawer of other times that Steven or other people have been unfair or unsupportive. I think that might be happening to you now. Can I help you take a step back, and maybe take some deep breaths to clear out some of those old memories so that we can talk about what it's like for you when Steven is critical—but just focus on this one time?

ANN: (*after a reflective pause*) I think that I am a very good mother. Our son Peter has some learning problems that make working with numbers very challenging. He's only 8 now, so we didn't really understand his problem deciphering columns until this year. He has a tutor to help him now, and we have all been told that this will take time to sort out. I can help Peter with his homework at home, but he's on his own when he has to do a test in school. The teacher knows that he is working on this, and he's not going to fail his year, but we all need to know what he still gets wrong. Steven has no right to blame me for this, or to go crazy when his son does poorly on a test. He can't tolerate anything less than perfection—in me or in the children.

Accessing Memories

According to current neuroscience research, memories are called upon to provide meaning and allow individuals to interpret and respond in a time-efficient way. I liken this to leaves on a vine. Each leaf stores specific memory fragments but they are stored on a vine that represents a central theme and related emotional experience. The memory that is activated in order to create meaning may be conscious or unconscious but is close to the surface once it has been activated. In most cases it can be made conscious and open to exploration simply by asking for an example that repeats the theme and emotion that is being discussed, as exemplified in the following exchange.

CASE ILLUSTRATION

THERAPIST: Steven, can we talk about what happened for you when you saw that Peter had failed his test?

STEVEN: It's a knee-jerk reaction. I just know he can do better if he slows down, and I think that Ann might not be coaching him in the best way.

THERAPIST: I hear you saying that you want the best for everyone in your family, but you count on Ann to do the things you can't do because you're working.

STEVEN: Exactly.

THERAPIST: Can you tell me what would go on regarding homework in your family when you were about Peter's age?

STEVEN: Well, I don't have any memories of either of my parents helping me with my homework. They both worked full-time, and me and my brothers were pretty much on our own.

THERAPIST: So there might have been a time when you felt overwhelmed at not understanding something you had to work on, and not able to get help from anyone?

STEVEN: Yes, I can remember more than one time that happened.

THERAPIST: That must have been terrible for a young kid to have to experience.

STEVEN: I haven't thought about it for a long time. I think I would just shut my book and watch TV or something to kind of rescue myself.

THERAPIST: Do you think that affected your school performance?

STEVEN: (*starting to tear up*) It's the greatest disappointment in my life. I never learned how to study or apply myself properly. No one cared as long as I passed, but my grades were terrible. I didn't get into any of the universities I applied to and had to go to a community college. I only have an associate's degree, and I am very embarrassed about that.

THERAPIST: I remember that you told me you were the one who encouraged Ann to quit her job and be a full-time Mom.

STEVEN: Yes! I don't want my children to go through life not living up to their potential.

THERAPIST: And you don't want your children to have to feel as bad as you remember feeling if they can't get things right.

STEVEN: (*Nods.*)

THERAPIST: And somehow you don't trust that Ann will share that goal and be the mom who is there to help, not like your mom. It seems that you can get angry when you feel like your children are not being protected or parented in a way that is very different from your own experience of being neglected, but we need to find a way to slow down your anger so it's not knee-jerk any more.

STEVEN: I never saw it that way before, but that makes sense.

THERAPIST: Ann, I'm not trying to excuse Steven's outburst, but can you comment on what Steven has said?

ANN: I knew that Steven wasn't a star student, but I didn't understand how that was connected to his mother not being there for him. I think that he needs to trust that I share his values and think about that before he attacks.

THERAPIST: I'm not suggesting that you agree that he can continue to attack you, but we can find ways of responding that will help prevent it from getting worse. I think it's time to talk about your reaction to being blamed. Can you tell me what it was like when Steven jumped down your throat about the math test?

ANN: Well, it's just not fair. He likes to blame me when anything goes wrong, and I'm sick of it.

THERAPIST: You felt angry that he accused you. Is it being blamed unfairly or his assumption that you won't be able to do it correctly that hurts the most?

ANN: Both.

THERAPIST: I know that you felt very protected by your father, but I'm wondering if this was something that would go on between you and your mother. Do you remember times that your mom attacked you without trying to see your side of the story?

ANN: It really didn't happen that often. I usually did pretty well, so it wasn't an issue.

THERAPIST: But somehow, I get the sense that your mother had high expectations and could blame people when things went wrong. Is that right?

ANN: For sure, but it was my dad who was always getting it. She was always comparing him to her sisters' husbands who made more money or went on better vacations or had a bigger house. And we weren't poor. I mean we had a comfortable home, but nothing was good enough for my mother.

THERAPIST: And you watched your dad getting criticized over and over. I wonder if that affected you, given how close you were to him.

ANN: Of course, it affected me. It was terrible. He was a good man, and he didn't deserve to be put down like that.

THERAPIST: I can see you're getting angry just remembering it. Sometimes, when we see things like that, we make a vow that we will never let anyone treat us that way. You couldn't make your dad stand up to your mother, but you seem to want to make sure that Steven can't do that to you.

ANN: Is that wrong?

THERAPIST: I'm not criticizing you at all. I'm just trying to help you both understand why this theme causes so much emotional distress for you. Steven, can you comment on how Ann's experience watching her parents has contributed to this pattern?

STEVEN: I know my in-laws—they still do this. I just never saw myself acting like my mother-in-law. I don't respect her for it, and I'm sorry to see that I've been doing that in my own life.

THERAPIST: Understanding why we react to these kinds of situations is the first step in knowing how to make changes. Today we've uncovered two important themes that probably play out in other situations where you've ended up in conflict or upset with each other.

> Now we can start to figure out how to put the past into perspective so you can have more choice in how you react to each other.

Connecting the Dots

Working with shared themes involves reflecting on the ways that both partners are invested in the dynamic. When partners are able to comprehend the aspects of earlier intimate relationships that have surfaced in the way they interpret and react to each other, they are more likely to be supportive to each other and more invested in finding new ways to resolve repeating conflicts.

The ultimate goal of couple therapy is not only to help the couple work through the issue that brought them to counseling but also to add to their skills and understanding of themselves and each other. In the therapy sessions, partners are helped to identify the specific events that trigger strong reactions and to better understand how past events may be influencing their emotional response. They are then helped to raise the problem in ways that their partner can hear and relate to and, together, challenge any incorrect interpretations or assigned meaning. Learning how to know when they are splitting or too emotionally distraught to communicate effectively is a skill that can last a lifetime. Partners learn the value of repairing emotional injuries, so that they do not add to the content of the "all-bad" drawer.

Creating Attunement and Empathy

The capacity to understand and to feel understood is a key component of a successful relationship and points to a major goal of object relations couple therapy. Livingston (2009) suggests that a partner's failure to care about the other's pain is as harmful as the behavior that caused the injury in the first place. Lack of empathy creates an additional disappointment that compounds alienation and mistrust. Helping partners speak in a way that can be heard is part of the solution, but equally important is creating a receptive position for the partner to hear. A partner who minimizes, deflects, or counterattacks has taken a defensive posture that prevents connection and effective problem solving.

Scharff and Scharff (1991) defined the "holding environment" as a critical component of an intimate relationship. This requires an empathic listening stance that asks one partner to understand the other's experience. Helping partners present their feelings and needs in nonattacking ways is an essential aspect of this process, and it usually requires that the therapist work with the speaking partner to clarify underlying emotions. In this process, the therapist is creating a holding environment that allows the speaker to grasp more fully and tolerate the troubling issue.

It is equally important to work next with the other partner and help in relating to the emotion that has been expressed. Partners will not feel empathic when they feel threatened, attacked, or overwhelmed by guilt or shame.

Separating Past from Present

The therapist who understands the power of the past can suggest that the theme involved in the problem between partners may have special meaning because of earlier experiences. Providing space for repressed memories to emerge and be shared in an empathic environment is a healing opportunity—but it is equally important to show how the present situation may be similar to but not the same as the earlier experience.

Constructing New Ways of Tolerating and Managing Difference

The power of the past should not be underestimated, as it often provides the key to understanding assumptions, expectations, reactions, and the ways that partners defend themselves. The uncovering of past influences provides an opportunity to change a posture between two people that was unacceptable or even damaging. Children have few options to create changes in relationships with rigid parents or to make parents change the way they are relating to each other. Instead, the children develop coping mechanisms and strategies for survival. When similar issues emerge in their adult lives, partners have the potential to bring new strengths and skills to resolve problems that have defeated them in the past.

The therapist can play a vital role in helping partners test new ways of relating and solving recurring problems. In order to accomplish this, each partner needs to see that the other is different from the earlier object, and that they are both different from their childhood selves. Barrett (2017) refers to "prediction error," as an individual is able to distinguish elements from the present that contradict the schema from a past memory.

CASE ILLUSTRATION

By the fifth session, Ann and Steven had uncovered important themes that played a role in misunderstandings, disappointments, and conflicts. In addition to helping uncover and make sense of the power of the past, I had helped validate the strengths in this couple as they made changes such as collaborating on cleanup or attending the transfusions. However, both had difficulty expressing their needs and had not been able to do that outside of the therapy sessions.

THERAPIST: I'd like to take another look at one of the things we talked about in our work. I remember how you used to argue about cleaning up the pots. As I've gotten to know you a little better, it seems that you, Ann, find it very challenging to ask for help, and assume that Steven will judge you harshly. And you, Steven, just brushed it off when I noted how much stress you were under, and if you had shared that with Ann. Can we spend a little time on that today?

STEVEN: I'm not sure that's something I want to change. I am not a complainer by nature, and I don't want any sympathy. If I have chosen to work hard to provide for my family, then I am proud to be able to do that.

THERAPIST: I'm not suggesting that you shouldn't be proud, but I'm curious about how much you share with Ann. Sometimes I get the sense that you are trying to protect her.

ANN: That's not how it feels—especially when he gives me sarcastic jabs or the look that makes me feel like I'm complaining or an invalid.

THERAPIST: Ann, I want to explore that as well, but for the moment, let's focus on Steven. I'd like to get a better understanding of what sympathy meant for you growing up. Is that okay?

STEVEN: I don't think it's relevant. I told you before that my brothers are competitive and pretty tough, and we would tease each other if someone couldn't keep up.

THERAPIST: Sometimes teasing can be pretty harsh and make people feel very bad about themselves.

ANN: Tell me about it.

STEVEN: I don't see the downside. It's a tough world out there and learning to take the heat can make you more successful. Stronger, if you know what I mean.

THERAPIST: I can see that strength is an important virtue in your family. Were both of your parents strong?

STEVEN: Well, my dad was for sure. Still is. He's almost 70 and still working every day.

THERAPIST: What about your mom?

STEVEN: (*speaking more pensively*) Well, my mom is another story. I think she sometimes felt left out with only boys in my family.

THERAPIST: Can you think about a time when you were aware that your mom was struggling?

STEVEN: I remember when I was little—maybe 8 or 9, and she was standing by the kitchen sink making dinner. And she was crying. Like there were tears dripping into the sink.

THERAPIST: What are you feeling as you remember this?

STEVEN: I remember feeling overwhelmed. I didn't know what to say, and I didn't know how to help her feel happy again.

THERAPIST: So being around her tears made you feel sad and also powerless. What did you do?

STEVEN: I think I just stayed there for a few minutes and then went back to the basement to play with my brothers.

THERAPIST: I'm struck by the impact that had on you. I wonder if in some way it made you want to protect her so that she wouldn't have to cry again?

STEVEN: Probably. I think she sometimes asked me how my day was, but I never remember telling her that anything bad was going on—even if it was.

THERAPIST: What if some of your beliefs about how much women can handle and your discomfort being around women who cry are still active today with Ann?

STEVEN: I never thought about it that way before.

THERAPIST: Ann, I know that you want to talk about what it's like for you to be teased, but before we do that, do you see yourself as being similar to Steven's mother—not able to be strong enough to help him when he has a problem?

ANN: That's absolutely ridiculous. I may get tired easily, but I'm not afraid of helping people solve problems.

THERAPIST: Ann, help me understand the difference between helping people solve problems and sharing emotions.

ANN: Well, I'm not sure that I'm very good at that.

THERAPIST: I remember that you told me when you were little, your dad would just know when you were upset or sad, and he knew just what to do to help you feel better. What did he do?

Ann: Well, he would ask me what was wrong, and then we would talk about ways to make it better.

Therapist: So you call that problem solving. But I think that by listening carefully and not dismissing your feelings, he was also offering you comfort and letting you know that you weren't alone.

Ann: That's true.

Therapist: So sometimes just listening without judging and encouraging someone to think of a way to make it better really helps. Do you think that you might be saying that you could offer that to Steven?

Ann: Well, I don't know his business very well, so I'm not sure I could come up with good ideas.

Therapist: Maybe it would just be enough to let him tell you without judging him and offering him some encouragement. Or just letting him know that you care. Or letting him know that he has a lot of pressures and that you appreciate what he goes through when he's "out there."

Steven: I would give anything for just a little appreciation.

Therapist: But you don't get it very often.

Steven: No. I don't think I get it at all.

Therapist: And at some level that makes you annoyed or angry. And sometimes you are sarcastic or act annoyed when you think Ann isn't carrying her share. What I see here is a cycle that both of you share for different reasons. Ann, you don't come to Steven when you need support because you think that if he loved you, he would just know what to do, just like your dad. But Steven isn't a parent, and by not opening up, you are saving yourself from learning how to be vulnerable and exposed. Steven, you hold a belief that women shouldn't be troubled by problems and a whole childhood of believing that people are all like your brothers, who would torment you if you exposed any weakness. It seems like you did well together when both of you felt strong, but neither of you was prepared to know how to get support or give it when things got tough. And yet, here, in our sessions, I have found that you both listen very carefully when I prompt your partner to open up and have come up with ways of changing the way things happen at home without much direction from me. What would have to happen for you to be able to trust each other in a new way at home and challenge the idea that weakness is dangerous or that your partner wouldn't respond in a way that is comforting?

Ann: Maybe it should start by us just asking each other? That would make it easier for me, I think.

Steven: I have a lot to think about. But I know that I really want to feel Ann's support and I can see how I haven't given her that chance.

Strengthening Empathy and Attunement

The importance of validation plays a central role in several approaches to therapy, and it has a prominent role in object relations couple therapy as well. An empathic, respectful client–therapist relationship is one of the most relevant components of successful therapy (Castonguay & Beutler, 2006). In couple therapy, it is possible not only to create attunement between the therapist and the partners but also to build the capacity for partners to provide empathy and attunement to each other. There are abundant opportunities for therapists to ask partners to comment on what they have learned after the therapist has opened up patterns and unveiled past events that had not been previously shared, and opportunities to help them offer compassion for their partner's childhood pain. Often, individuals who are defensive when their own behavior is being focused on, soften and can offer comfort when the "problem" is located elsewhere.

Termination

Although this model can help prevent early termination related to unaddressed splitting, there are few guidelines to instruct the timing of a planned termination. Object relations concepts provide an entry into a fascinating world of psychic functioning, but few couples have the time, financial resources, or commitment to pursue therapy for the sake of self-improvement. As couple therapists, we struggle with the responsibility of not only providing the focus and tools for the work but also knowing when the work is complete (Siegel, 2010a). Systems theory posits the endpoint as the family's ability to establish a better equilibrium and return to its current life cycle stage with resilience. The couple's ability to function in an improved manner is sufficient proof of the therapy's success. Object relations theory uncovers themes and dynamics that may never be fully resolved, obscuring the possibility of true completion. Ultimately, the couple can prepare for termination when the initial goals that include the presenting problem from the couple's perspective have been resolved to both partners' satisfaction. Along the way, the partners will have found new ways of understanding and supporting each other and will have created a more stable relationship that allows reactions to help, rather than hinder, their connection.

Termination should be raised for consideration when the couple has reached a stable position, and when many of the treatment objectives have been addressed. It is not uncommon for partners who have had a successful therapy experience to express fear about termination, as they may worry about regressing or losing the stability that the therapy has provided. Termination, however, involves recognition of accomplishment, as well as the therapist's confidence in the couple to use their new skills and self–other awareness to maintain their gains. The couple described throughout this chapter ended therapy after about 10 sessions. When they returned some years later for some brief assistance with a problem they faced regarding one of their children, the fundamental shifts that had been accomplished in the earlier therapy remained intact.

MECHANISMS OF CHANGE

Prediction Error

The essence of object relations couple therapy is the ability to make sense of emotions that are stimulated, identify the trigger and theme that has been revived, uncover aspects of the past that have been activated in this process, and help partners find a new way of working this through with each other in a constructive way. While the therapist plays a central role in providing psychoeducation about the influence of the past and helping partners recognize beliefs that may not fully apply to the present, it is hoped that partners become more skilled at slowing down emotional reactivity in order to make sense of provocative issues that occur outside of therapy. It can be useful to assign names to this process, as partners alert each other to a potentially explosive interaction, and call on each other to find a different response. As this takes hold, partners begin to see each other as being potentially part of the solution, not just a repetition of former disappointing objects. When this occurs, the brain is able to distinguish how the leaf that was opened in order to construct meaning is not accurate, creating what Barret (2017) refers to as prediction error. A partner who can be viewed as potentially supportive or helpful is in stark contrast to the objects retained in earlier memories. These repeated experiences create new memories that can inform the present and create ongoing change.

The Ability to Observe One's Own Relationship Patterns

Members of a couple who have learned to join the therapist in reflecting on their reactions and making sense of their emotions develop the ability to observe themselves in a new way. The ability to step outside oneself in order to truly see oneself adds an important dimension and strengthens each partner's ability to manage extreme states. This is especially important in work with couples that have the intense, rollercoaster relationships defined by dyadic splitting. The capacity to observe oneself, or develop an observing ego, leads to better judgment and improved impulse control.

Emotional Intelligence

The process of unraveling projective identifications helps strengthen the ability to identify, comprehend, and talk about experiences that are initiated in the emotional realm. As a result of working with the therapist to manage uncomfortable feeling states, and to question the meaning and memories that have played roles in events, partners develop skills in emotional intelligence. The ability to comprehend emotions rather than implode or explode allows for a more thoughtful understanding of emotional triggers (Siegel, 2010c, 2012).

In order to facilitate this kind of growth, the therapist must also possess a high degree of emotional intelligence. This is particularly important in the work that is required to unravel emotions that are stimulated through countertransference. When raw emotions surface in a session, they may be poorly understood and cause overreaction. The ability to manage discomfort and tolerate the experience is like bringing a looking glass to a situation that seems to be murky shades of grey. The looking glass allows shapes to become distinct and recognizable, adding clarity and meaning.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

This approach to couple work provides opportunities for recognizing and subduing the influence of splitting, and for diminishing the power of the past. As a result, it can be particularly relevant for couples with trauma histories, with narcissistic or borderline tendencies, and for couples whose relationships are volatile and unstable due to splitting. There are theoretical assumptions that may make this model suitable for interventions with mutually escalating interpartner violence, as well as for couples with addictions (Siegel, 2013). In many of these populations, it can be very helpful for one or both partners to be in individual treatment in order to get the support and ability to work through themes that have been raised in the couple sessions. Some individuals may also need help strengthening emotional processing or managing trauma reactions and would benefit from individual approaches that specialize in those areas.

Given the emphasis on subjectivity and the lack of strictly ordered sequencing of interventions in this model, it has been challenging to conduct rigorous empirical investigation. It would be very difficult and perhaps counterproductive to manualize this approach, and almost impossible to replicate sequenced interventions across cases. However, some of the concepts that this model employs have been studied. The Dyadic Splitting Scale has been researched in populations with partner violence (Siegel & Spellman, 2002). The concept of flooding has been found to play a role in heightened emotional responses related to anger in cohabiting couples (Foran, Lorber, Malik, Heyman, & Slep, 2020; Malik, Heyman, & Slep, 2020). Additional empirical support can be found in research examining the ways that memory informs the construction of meaning and ongoing research on the emotional brain (Hutchinson & Barrett, 2019).

CONCLUDING COMMENTS

Object relations couple therapy is based on the premise that one's choice of partner, style of managing conflict, and ability to express needs, expose vulnerability, and receive and provide nurturing are, to varying degrees, products of early family relationships. Relational dynamics acquired in childhood are not immutable, but their influence cannot be adequately challenged until the vestiges and residues are identified and understood. Doing so requires that the couple therapist provide a safe environment for exploring emotions in order to unravel memories and associations that have not been previously understood. Only then can partners make the connections between how the past has comingled with the present in ways that complicate their ability to construct the relationship they seek.

SUGGESTIONS FOR FURTHER STUDY

Barrett, L. F. (2017). The theory of constructed emotion: An active inference account of interoception and categorization. *Social Cognitive and Affective Neuroscience, 12,* 1–23.

Lane, R. D. (2018). From reconstruction to construction: The power of corrective emotional experiences in memory reconsolidation and enduring change. *Journal of the American Psychoanalytic Association 66,* 507–516.

Livingston, M. S. (2009). Sustained empathic focus and its application in the treatment of couples. *Journal of Clinical Social Work, 37,* 183–189.

Siegel, J. P. (2004). Identification as a focal point in couple therapy. *Psychoanalytic Inquiry, 24,* 406–419.

REFERENCES

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Bandura, A., & Walters, R. H. (1963). *Social learning and personality development.* New York: Holt, Rinehart & Winston.

Barnett, J. (1971). Narcissism and dependency in the obsessional–hysteric marriage. *Family Process, 10,* 75–83.

Barrett, L. F. (2017). *How emotions are made: The secret life of the brain*, Boston: Houghton Mifflin Harcourt.

Castonguay, L. G., & Beutler, L. E. (2006). *Principles of therapeutic change that work.* London: Oxford University Press.

Cozolino, L. (2016). *Why therapy works: Using our minds to change our brains.* New York: Norton.

Foran, H, M., Lorber, J., Malik, J., Heyman, R. E., & Slep, A. M. S. (2020). The Intimate Partner Flooding Scale. *Assessment, 27,* 1151–1162.

Horowitz, M. J. (1977). Cognitive and interactive aspects of splitting. *American Journal of Psychiatry, 134,* 549–553.

Hutchinson, J. B., & Barrett, L. D. (2019). The power of predictions: An emerging paradigm for psychological research. *Current Directions in Psychological Science, 28,* 280–291.

Jacobson, E. (1964). *The self and the object world.* New York: International Universities Press.

Kernberg, O. F. (1985). *Borderline conditions and pathological narcissism*. New York: Aronson.

Koch, A., & Ingram, T. (1985). The treatment of borderline personality disorder within a distressed relationship. *Journal of Marital and Family Therapy, 11,* 373–380.

Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.

Lansky, M. R. (1981). Treatment of the narcissistically vulnerable couple. In M. Lansky (Ed.), *Family psychotherapy and major psychopathology* (pp. 163–182). New York: Grune & Stratton.

Livingston, M. S. (1995). A self psychologist in couplesland: A multisubjective approach to transference and countertransference. *Family Process, 34,* 427–439.

Livingston, M. S. (2009). Sustained empathic focus and its application in the treatment of couples. *Journal of Clinical Social Work, 37,* 183–189.

Mahler, M. (1975). *The psychological birth of the human infant*. New York: Basic Books.

Malik, J., Heyman, R. E., & Slep, A. M. S. (2020). Emotional flooding in response to negative affect in couple conflicts: Individual differences and correlates, *Journal of Family Psychology, 34,* 145–154.

McDevitt, J. B., & Mahler, M. (1986). Object constancy, individuality and internalization. In R. F. Lax, S. Bach, & J. Burland (Eds.), *Self and object constancy* (pp. 11–28). New York: Guilford Press.

Meissner, W. W. (1978). The conceptualization of marriage and family dynamics from a psychoanalytic perspective. In T. Paolino & B. McCrady (Eds.), *Marriage and marital therapy* (pp. 25–88). New York: Brunner/Mazel.

Meissner, W. W. (1982). Notes toward a psychoanalytic theory of marital and family dynamics. *International Journal of Family Psychiatry, 3,* 189–207.

Nelsen, J. (1995). Varieties of narcissistically vulnerable couples: Dynamics and practice implications. *Clinical Social Work Journal, 23, 59*–70.

Richter, H. (1974). *The family as patient* (D. Lindley & H. Lindley, Trans.). New York: Farrar, Straus & Giroux.

Sandler, J., & Rosenblatt, B. (1962). The concept of the representational world. *Psychoanalytic Study of the Child, 17,* 128–162.

Scharff, D., & Scharff, J. S. (1991). *Object relations couple therapy*. Northvale, NJ: Aronson.

Schwoeri, L., & Schwoeri, F. (1981). Family therapy of borderline patients: Diagnostic and treatment issues. *International Journal of Family Psychiatry, 2,* 237–250.

Sharpe, S. A. (1981). The symbiotic marriage. *Bulletin of the Menninger Clinic, 45,* 89–114.

Siegel, J. P. (1992). *Repairing intimacy: An object relations approach to couples therapy.* Northvale, NJ: Aronson.

Siegel, J. P. (1995). Countertransference as projective identification. *Journal of Couples Therapy, 5,* 61–69.

Siegel, J. P. (1997). Applying countertransference theory to couples treatment. In M. F. Solomon & J. P. Siegel (Eds.), *Countertransference in couples therapy* (pp. 3–22). New York: Norton.

Siegel, J. P. (1998a). Defensive splitting in couples. *Journal of Clinical Psychoanalysis, 7,* 305–327.

Siegel, J. P. (1998b). Splitting as a focus of couples treatment. *Journal of Contemporary Psychotherapy, 38,* 161–168.

Siegel, J. P. (2000). *What children learn from their parents' marriage*. New York: HarperCollins.

Siegel, J. P. (2004). Identification as a focal point in couple therapy. *Psychoanalytic Inquiry, 24,* 406–419.

Siegel, J. P. (2006). Dyadic splitting in partner relational disorders. *Journal of Family Psychology, 20,* 418–422.

Siegel, J. P. (2010a). A good enough therapy: An object relations approach to couple treatment. In A. S. Gurman (Ed.), *Clinical casebook of couple therapy* (pp. 134–152). New York: Guilford Press.

Siegel, J. P. (2010b). Object splitting. In I. B. Weiner & W. E. Craighead (Eds.), *Corsini's encyclopedia of psychology* (4th ed., Vol. 3, pp. 1111–1112). Hoboken, NJ: Wiley.

Siegel, J. P. (2010c). *Stop overreacting.* Oakland, CA: New Harbinger.

Siegel, J. P. (2012). Denial, dissociation and emotional memories. *Couple and Family Psychoanalysis, 2,* 49–64.

Siegel, J. P. (2017). Internalization in psychoanalytic couple and family therapy. In J. L. Lebow, A. L. Chambers, & D. C Breunlin (Eds.), *The encyclopedia of couple and family therapy*. Cham, Switzerand: Springer.

Siegel, J. P. (2020). Digging deeper: An object relations couple therapy update. *Family Process, 59,* 10–20.

Siegel, J. P. (2021). Couple therapy. In J. Brandell (Ed.), *Theory and practice in clinical social work* (3rd ed., pp. 221–235). San Diego, CA: Cognella.

Siegel, J. P., & Spellman, M. (2002). The Dyadic Splitting Scale. *American Journal of Family Therapy, 30,* 93–100.

Singer-Magdoff, L. J. (1990). Early fit and faulty fit: Object relations in marital therapy. In J. F. Crosby (Ed.), *When one wants out and the other doesn't* (pp. 118–135). New York: Brunner/Mazel.

Slipp, S. (1984). *Object relations: A dynamic bridge between individual and family treatment.* New York: Aronson.

Solomon, M. F. (1985). Treatment of narcissistic and borderline disorders in marital therapy. *Clinical Social Work Journal, 13,* 141–156.

CHAPTER 8

Mentalization-Based Couple Therapy

Efrain Bleiberg, Ellen Safier, and Peter Fonagy

Two truths approach each other
One comes from within
One comes from without
and where they meet
We have the chance to see ourselves
—Tomas Tranströmer, "Preludes" (1972)

BACKGROUND

The intimacy of a couple relationship is the closest approximation for most people of the experience of being in therapy. In a couple relationship we confront the most uncomfortable truths about ourselves, our greatest fears and vulnerabilities, those aspects of our selves that feel "alien" and are not well integrated into the fabric of the narrative we have constructed about who we are.

But a couple relationship also provides us with the context in which our mentalizing strengths come to life. It is where we experience our deepest longings and our most tender hopes. In the other person's embrace and recognition, we have the best "chance to see ourselves," find the greatest sense of safety, trust and reciprocity, and the optimal opportunity to flourish. It is in co-mentalizing, in mutual learning and understanding, that we find the fulfillment of our human potential.

It would thus seem that working with couples in therapy is a most natural context for the application of the framework of mentalization-based therapy (MBT). MBT as a treatment approach was first tested empirically with adults with borderline personality disorder (Bateman & Fonagy, 2016). Subsequently MBT has been applied transdiagnostically to a range of mental health conditions and patient populations, including trauma (Allen, 2013), eating disorders (Robinson et al., 2016), psychosis (Debbané et al., 2016), depression (Fonagy et al., 2019), and substance-use disorders (Phillips, Wennberg, Kondrasson, & Frank, 2018), as well as to children (Midgley, Ensink, Lindqvist, Malberg, & Muller, 2017), adolescents (Rossouw & Fonagy, 2012), infants and mothers (Sadler, Slade, & Mayes, 2006), and families (Asen & Fonagy, 2012).

MBT focuses on teaching, modeling, restoring, promoting, and rehabilitating mentalizing and epistemic trust and the associated capacity to learn socially and emotionally in close relationships. Any introduction to the conceptual framework underpinning MBT and MBT for couples (MBT-CO) would have to start with a definition of the key processes of mentalizing, epistemic trust, and symbolic/representational/imaginative processing.

Mentalizing refers to the skills and attitudes we deploy to notice, recognize, understand, and take into account the perspective and intentions of other people, as well as our own (Fonagy & Bateman, 2016). The first challenge faced by the practitioner of MBT is to explain, let alone demonstrate, what it is that we do when we mentalize, how we actually put into practice the very skills and attitudes we are seeking to support, promote, model, and rehabilitate. Some of the difficulties explaining mentalizing arise from the fact that it is not a single, unitary action or set of activities. Instead, the mentalizing attitude depends on the capacity to hold a dynamic, flexible, constantly shifting balance between two modes of processing.

The first mode of processing is a very fast, visceral, emphatic form of automatic mentalizing that comprises intuitive, procedural patterns—that is, nonconscious patterns of affect, movement, physiology and perception through which we seek to inhabit or resonate with other people's experience—so we can understand the other from the inside. But this effort to create a visceral simulation of the other person's experience also operates in the opposite direction, that is, by inducing in the other, through procedural means, a similar matching of our own experience. This mode of processing thus generates a sense that "what is in my mind is in your mind, and what is in your mind is in my mind"—a state that Fonagy and Target (1996) describe as "psychic equivalence." The directionality of the inducement of visceral simulation is governed by the level of stress: The higher the stress level, the more we seek to coercively evoke in the other a simulation of our own experience, perhaps a legacy of the evolutionary adaptation aimed at ensuring that caretakers could feel their babies' states of need via the activation of their mirror neuron system.

On the other hand, when stress levels are low and we feel protected, recognized, and understood, the direction of the psychic equivalence flows in the opposite direction, as we resonate and inhabit the other person's experience and perspective; this is part of the process described later as epistemic trust. The procedural experiences of automatic mentalizing are stored as implicit memories, which are triggered without deliberation or effort (Luyten & Fonagy, 2015).

A second mode of processing that involves slower, more cognitive, conscious, or potentially conscious, symbolic/representational means of processing is "controlled mentalizing." It requires effort and attention, reflection, and interpretation, through which we not only imagine the other person's intentions, perspective, and mental states, but also are able to imagine the impact we—and our mental states—have on others, that is, a process through which we understand ourselves from the outside. These controlled, symbolic/representational experiences are stored as explicit memories, which are retrievable through introspection and are connected to symbolic/representational categories and patterns that seek to generate not a procedural match, but a coherent representation of our experience.

Thus, the attitudes and skills of mentalizing involve a balancing act, a balance that is constantly lost and then recovered, of focusing on self and focusing on the other, of predominantly automatic/procedural/implicit processing and of more controlled/symbolic-representational/explicit processing. It is precisely when this flexible state of balance is generated—as opposed to when we get stuck in an unbalanced, no longer shifting and adjusting point of predominance of automatic, visceral simulation (the psychic equivalence mode) or of controlled, representational mentalizing not anchored by a link to affect and empathy (the pretend mode), that we are able to function in a "Goldilocks" state of arousal and alertness, affect, and cognition—not too little, not too much, but just right. In such a state we can recognize, understand, and take into account the other while able to feel recognized, understood, and taken into account ourselves. It is the feeling of being mentalized that serves as the glue that binds together an intimate couple.

The qualifier of "epistemic" in epistemic trust refers to the notion that the experience of being mentalized indicates to us that we can safely turn off defensiveness (epistemic vigilance) and count on the other person to be sensitive, responsive, and credible. By conveying that the other person is epistemically trustworthy—that such person can be trusted to be safe and communicate credible information—we are able to internalize and integrate such information into our framework of representations of ourselves and the world. This information is understood as generalizable and is the key to socioemotional learning and thus adaptation.

Developmentally, mentalizing and epistemic trust are rooted in the innate disposition, present in all humans at birth, to seek attachment in response to threats (Bowlby, 1969). From this perspective, our physical survival and the integrity of our brain, buffeted by stress, depends on our ability to signal distress to others who, in turn, are disposed to mentalize, that is, to effectively recognize and accurately interpret those distress signals in a timely, protective, regulating, and soothing manner. An important lesson from infancy research, however, is that optimal development, at least for infants of average sensitivity, does not require perfect attunement or accuracy (Beebe et al., 2010). On the contrary, infancy research and observation point out that average, "good-enough" mothers (Winnicott, 1971), effectively mentalize one of every three of their babies' signals (Gianino & Tronick, 1988).

Such ratio of success/failure—which some studies suggest may be similar to the mentalizing success ratio demonstrated by the "good-enough" therapist with their patients—gives evidence that normal development is marked by constant small failures of attunement, necessitating effective repair of the attachment relationship thrown out of kilter by the misattunement and the associated defensive response. It does appear that what heralds controlled mentalizing and epistemic trust is this very process of failure and repair. One central objective of MBT-CO is to rehabilitate the couple's ability to repair misattunements, misunderstandings, and the associated breakdowns in mentalizing and epistemic trust. Such repair renders the breakdowns as opportunities to grow, learn, and heal rather than experiences of catastrophic failure.

Mentalizing may have evolved, first and foremost, as a mechanism to ascertain who, when, and how much we can or cannot trust a potential attachment partner. A mentalized assessment of other people's intentions provides a flexible, more accurate, and effective way to decide when, with whom, and how much to allow for emotional and physical closeness, as well as remaining open to believe in and learn from our attachment partners. On the other hand, mentalizing the other's malignant or dismissive mental states serves to activate defensive responses of anxiety, anger, or detachment that act as barriers to keep at bay the other person and the information they convey. When we deem the other as trustworthy because we feel mentalized, we experience a decrease in defensiveness and in the sense of emotional distance. Mentalizing is then partially deactivated and, with it, the critical social judgment about the intentions, the veracity, and the usefulness of the other person and their communications (Bartels & Zeki, 2004). As defensive, distancing affects, such as shame, disgust, and anger, are turned off and we allow for greater emotional and physical proximity and cognitive credulity, we experience a growing merging of our boundaries, as occurs when we fall in love. Indeed, partial abandonment of critical social judgment and the sense of merging of self boundaries may be a necessary condition to falling in love.

When we feel threatened by others, we also switch off mentalizing. However, the breakdown in mentalizing and the increased defensiveness of other people are not the only triggers of defensiveness and nonmentalizing in ourselves. All of us carry "mentalizing lacunae" (gaps), the legacy of adversity and vulnerability, and our efforts to cope with contexts in which certain aspects of our experience were not mentalized and integrated into our self-representations and are thus experienced as alien parts of the self, aspects whose activation elicits a defensive response. These may include experiences of defeat or deflation, frustration or competition, loss, abandonment, rejection or shame, humiliation, guilt, or control by someone else's needs. Even experiences of triumph or exhilaration can feel alien and elicit a defensive response.

Defensiveness involves an increase in the sense of emotional distance from the other with a corresponding increase in arousal and activation of the "fight–freeze–flight" response. As arousal and defensiveness increase, the balance of automatic and controlled mentalizing breaks down, and these two components tend to uncouple, ushering either the predominance or alternation of psychic equivalence—with its coercive efforts to impose our truth on the other and the complete certainty about our perspective or, on the other hand, the pretend mode in which nothing feels real and feelings can be dismissed.

Evolution has built into the human brain a disposition to respond automatically with defensiveness and loss of mentalizing when approached by others who show defensiveness, coerciveness, and nonmentalizing. Visceral experiences of arousal and stress powerfully evoke similar responses in others. This disposition is greatly intensified in intimate relationships. Such intensity is hardly surprising. As the support and containment offered to the couple by extended family and community have eroded in industrialized societies, intimate partners are left to rely mostly on each other for support of their identity, emotional well-being, and self-worth.

Relying so heavily on their intimate partners, members of a couple can feel utterly vulnerable, as the costs of misunderstanding are very great. Put simply, we experience the greatest difficulty remaining in a mentalizing mode with our intimate partners because those who are closest to us matter too much. Such vulnerability to losing mentalizing inevitably impacts our partners. Thus, transactional sequences are often set in motion in which one member of the couple, displaying defensiveness, increased arousal, or detachment, certainty, coercion, and loss of mentalizing, evokes a similar reaction in the partner, which, in turn, reignites more nonmentalizing and creates a vicious cycle of reactivity and dysregulation. Perhaps more significantly, they deprive the couple of the protective and restorative functions (to be seen, to be safe, to feel soothed, to enjoy sex) provided by intimate attachments built out of mentalizing, trusting, and social learning.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

Most couples, like most individuals, are capable of mentalizing more or less effectively, at least sometimes, and do so automatically, without conscious effort. The first step in conducting MBT-CO is an assessment of the couple's history, functioning, and the extent to which the partners are able to maintain—and recover—a mentalizing stance that involves (1) feeling recognized and understood by their partner; (2) having a shared sense of safety and trust in each other that includes a taken-for-granted conviction that they can count on their partner to be on their side; (3) finding in each other an "epistemic partner" that provides credible information, important for survival, successful adaptation, and repair of breakdowns; (4) utilizing the couple relationship both as (a) a "secure base" that invites exploration, playful interactions and new learning, and discovery within the relationship and (b) a "safe haven," a soothing, comforting harbor from the storms and tribulations of life (Bowlby, 1969); and (5) locating in the relationship with the partner the erotic tension that is predicated on the right distance—between intimate closeness and erotically charged "otherness"—that generates sexual intimacy and pleasure (Perel, 2006).

When mentalizing is ineffective, it is dominated by one or more of three modes of representing internal states. The first is psychic equivalence, which is characterized by excessive certainty, a suspension of the doubt and humility associated with the natural opaqueness of mental states (in effect, our own, as well as those of others). In psychic equivalence, thoughts and feelings have an absolute reality. There is a finality to them and a lack of openness to consider other possibilities. For example, in the middle of a conversation, if one sees their partner looking at their watch, they believe this unequivocally means that their partner is bored with them and can't wait for the conversation to be over.

The second is the pretend mode, which describes a different but often coexisting mode of ineffective mentalizing. The conversation between the partners and with the therapist may have the appearance of mentalizing, but it is inconsequential talk. Groundless and excessive inferences are made about mental states, even if these are positive in valence. Hypotheses about the partner's history or, indeed, details of the person's own history, may provide a mitigation for their actions but serve no useful purpose. There is a lack of connection between the thoughts and the words on the one hand and the person's feelings and actions on the other. Characteristically there is a circularity without conclusion in such a discourse, and a repetitiveness and unjustified complexity, termed by Carla Sharp as "hypermentalizing" (Sharp et al., 2016). It is essential to be wary of such pseudomentalizing, as it brings with it no progress and no therapeutic change.

The third and readily recognizable mode of ineffective mentalizing is the teleological mode, which is rooted in a lack of genuine belief in the relevance of thoughts and feelings in the determination of behavior and can be summarized by the expression "actions speak louder than words." Words in this mode carry little meaning, and there is the expectation that change must be observed to actually happen in order to be felt as meaningful. Outcomes in the physical world determine understanding of inner states. The teleological mode can lead to expectations that actions can repair psychological wounds. For example, in order to repair a fight, a man wonders why his partner is so unforgiving: "I brought you flowers. Isn't that enough?" Similarly, the teleological mode can lead to demands for actions in the illusory belief that a change in behavior will automatically generate a modification of attitude. Of course, if motives of others are judged by what actually happens (what you do and not what you think, feel, or say), then the therapy can become focused on complex behavioral contracts. This is not necessarily a problem, but it can lead to the avoidance of potentially painful recognition of problematic thoughts and feelings that in fact are the generators of the troublesome actions. The demand on the therapist can be to bring about a change in the partner's behavior, and discussions of internal states can be regarded as inconsequential.

Assessing these modes of representing internal states and the previously mentioned dimensions and modes of functioning between no, or a very limited, sense of safety and trust to a robust and rarely impaired sense of safety involves, in particular, identifying the specific interactive patterns in which one or more of these dimensions and the underlying capacity to mentalize and trust breaks down or becomes strained. For example, the defiant behavior of a teenage son may result in the father feeling dismissed and disrespected. He responds to feeling disrespected with rage, which leads the mother and wife to feel threatened, and to distance herself from her partner. She then sides with the teenage son, which results in an increased sense in the father of feeling dismissed and disrespected. This leads to more defensiveness, more psychic equivalence, less mentalizing, and less trust in the couple and the entire family.

John Gottman, in his book *The Science of Trust* (2011), summarizes the results of his extensive empirical studies of couples that reveal indicators of dysfunction in couples during conflict. We propose that such indicators are markers of a breakdown of mentalizing and epistemic trust, and include turning away, turning against, escalation of negative affect, failing to repair, maintaining vigilance, physiological arousal, failing to accept influence, and failure to learn from each other. The key result of feeling mentalized is to open oneself to the influence and the knowledge provided by the other; a breakdown in mentalizing and trust blocks the channel for mutual learning and curiosity. (See also Chapter 16, "Gottman Method Couple Therapy," in this volume.)

THE PRACTICE OF MBT-CO

The Structure of the Therapy Process

The process of MBT-CO begins with one to two assessment sessions with the couple followed by one or two individual sessions with each member of the couple. In these sessions, the therapist seeks to elicit a detailed understanding of the issues that brought the couple to treatment, their individual history, particularly their attachment history, the couple's history, and their mentalizing strengths and vulnerabilities (see Table 8.1).

The individual sessions provide an opportunity to better understand each member of the couple, including the history of how they influence each other's capacity to mentalize and trust, the interactions in which breakdowns in mentalizing and epistemic trust occur, and the coercive cycles such interactions generate. One aim of the individual sessions is to strengthen each partner's sense of being understood, recognized, respected, and validated, paving the way for trust in the therapist and in the therapy process.

In the individual session, the therapist explores partners' families of origin, relationship history, and views of current strengths (what one values in the partner and in the relationship and wouldn't want to change) and difficulties, as well as their commitment to the relationship and to the process that seeks to address challenges and repair problems. The individual sessions also offer an opportunity to assess each partner's personality, attachment style, and level of functioning—rigidity, flexibility, coping strategies, cognitive style, patterns of communication, and compatibility with their partner. Last, but not least, the individual sessions can serve to identify issues that are more difficult to discuss in the presence of the partner, including individual health and mental health issues, substance abuse, concerns about safety or domestic violence, and infidelity and trauma that both exacerbate and are exacerbated by difficulties in mentalizing. These issues require special consideration regarding how to help the couple deal with secrets they have kept from each other and how to create a safe space for the work, including an assessment of the couple's readiness for treatment (see Table 8.2).

Following the joint session and the individual sessions, the therapist meets with the couple to share a formulation that summarizes the therapist's understanding of the couple's strengths and challenges, particularly highlighting mentalizing strengths and vulnerabilities and difficulties in trusting and learning. The formulation also maps out a path to recovery. This formulation, in common with other MBT protocols, can be presented orally and in writing, which provides a useful reference and a document to review progress in the therapy. The process of assessing and sharing a formulation is also an opportunity to educate the couple about mentalizing, epistemic trust, and the process of mentalization-based treatment.

Education is typically handled in individual and couple sessions, with a focus on how the capacities for mentalizing are acquired in the context of our attachments and how the capacity for mentalizing and trusting are maintained or break down when defensiveness is activated. Education also includes sharing reading and video material. However, the key education about mentalizing, epistemic trust, and MBT takes place implicitly in the experience of the therapy.

As part of the formulation, the therapist proposes starting a process of sessions that, as was the case during the assessment, include couple sessions typically once weekly and the option for some individual sessions. One or both of the partners may be referred to individual psychotherapy, medication management, or alcohol and substance use treatment, which are indicated

TABLE 8.1. Questions to Assess Mentalizing for the First Joint Interview and Beyond

Trust and attunement

- How much do you feel “seen” or understood by your partner?
- Can you give me an example of when that has happened?
- How much do you imagine your partner feels “seen” or understood by you?
- How safe and trusting do you feel in your relationship with your partner?
- What have you learned about your partner over the years?
- How much do you feel you can put your guard down and trust that your partner is “on your side” or “has your back”?

Capacity for collaboration and intimacy

- How much do you feel you agree and support one another regarding children and parenting?
- What are the areas that you feel are most difficult for the two of you as parents?
- How do you collaborate in planning and managing your finances?
- What is your sexual relationship like for you? What do you imagine it is like for your partner?
- How do you express intimacy, affection, and caring to each other?
- How much do you rely on your partner for emotional soothing at times of stress?
- How do you help each other feel supported with your extended families?
- What are some challenges you have faced that you feel you handled well as a couple?

Handling conflict

- How good are you and your partner at repairing or apologizing after a disagreement or conflict?
- How much do you each take responsibility for your part in disagreements and conflicts?
- For example, if you each carry 10% of the responsibility for a given conflict (and “the cosmos” carries 80%), what do you imagine your part is?
- How do you and your partner handle issues of health and mental health?
- How easy or difficult do you think it is for you to listen to your partner when you are upset?
- What do you feel are the major stressors that are now impacting you as a couple?

Looking forward

- How much are you aware of and supportive of each other’s dreams and aspirations, as well as worries and fears?
- What are some of the areas of your lives that you are particularly happy with and would not want to change?
- If we work together and things go as well as they can, how would you like your relationship to look in 6 months? What would you like to be able to change for yourself?

when one or both partners present with significant mental health issues or in instances in which breaches in trust, such as affairs, require a considerable process of self-examination and understanding in order to navigate the journey to repair.

The Role of the Therapist

The therapist’s role is to support the couple’s capacity to maintain co-mentalizing (simultaneous interactional mentalizing) in the relationship. The primary aim of the therapy is to enable mentalizing in the context of the specific relationship, not to provide insight into its history or address intraindividual personality problems. In fact, the role of the therapist can be simply stated as assisting the couple in reinstating mentalizing when interactions between partners suggest that ineffective modes of mentalizing (psychic equivalence, pretend or teleological modes) replace effective joint thinking about the relationship.

The therapist introduces a mentalizing stance that brings to life how mentalizing is put into practice, including an attitude of genuine curiosity, openness, respect, and interest in understanding the perspective of each partner “from the inside.” Real tentativeness, humility, and tolerance for not knowing what the other person’s thoughts, feelings, and intentions “really are”

TABLE 8.2. Mentalizing Questions for the Individual Session of Each Partner

- How did you meet and get together? What attracted you to each other?
- What do you think your relationship has been like for your partner?
- How do you imagine your partner has experienced you?
- What was your relationship like with your parents growing up?
- How do you feel that might impact your relationship with your partner now?
- Was there a history of violence or abuse or separations in your family growing up?
- How do you communicate to your partner when you feel sad, hurt, disappointed, or anxious?
- What are the situations where you are most likely to become angry, defensive, critical, contemptuous, anxious, coercive, or detached?
- What would it take to turn those conflicts into conversations in which you could hear each other's point of view?
- What do you love and cherish about your partner, and how do you let your partner know?
- How committed are you to the relationship right now, and how hopeful are you that the problems can be resolved? On a scale of 1 to 10, in which 1 is *"I am leaving this office to consult with an attorney about divorce proceedings"* and 10 is *"I can never imagine getting a divorce, no matter what*," what number would you give yourself right now?
- What number do you imagine your partner would give?

is demonstrated by "what" questions ("Do you know what was going on for you when you said that?") and frequent checking. Checking demonstrates the therapist's effort to truly understand the partners accurately and a readiness to be surprised and enlightened by their contributions.

Particularly important is for the therapist to demonstrate "impact awareness," a keen interest in learning the effect of their own words and actions on the couple. Such inquiry serves to highlight the difference between the intent of one's actions and the impact they have on others, and the significance of not only considering the other person's perspective but also asking explicitly about their experience. Equally important is the therapist's readiness to acknowledge and take responsibility for their own inevitable mistakes and associated failures in mentalizing that cause pain and defensiveness for the couple. This acknowledgment helps to validate the couple's experience of feeling misunderstood and demonstrates how courage and humility can foster growth and repair. The therapist monitors instances of spontaneous mentalizing in the couple and highlights how a mentalizing attitude can offer the possibility for feeling more open and less guarded. Alternatively, noticing defensiveness can help both the partners and the therapist explore and understand feelings about the self or the relationship that include a sense of threat. Therapists can then help both partners recognize the bodily experience of defensiveness and help point to the specific ways each partner responds to defensive breakdowns in mentalizing—their own particular "four horsemen of the mentalizing apocalypse": criticism, contempt, defensiveness, and stonewalling (Gottman, 2011), as well as dismissiveness, anxiety, anger, avoidance, dissociation, detachment, pretending to be present and in agreement without conviction, unjustified certainty, and coercive efforts to make the other person feel, think, or act in a particular way.

Assessment and Treatment Planning

The assessment aims to flesh out the particular mentalizing strengths and challenges in each partner and the specific ways in which the partners' interactions enhance or compromise their capacity to mentalize and trust. Questionnaires to assess the couple's functioning include the Enhanced Gottman Relationship Checkup (Gottman, 2021), the Mentalization Questionnaire (Hausberg et al., 2012), and the Parent Development Interview—Reflective Functioning Scale (Slade, 2005); the latter is particularly useful when there are significant issues related to parenting.

Goal Setting

At the heart of MBT-CO is a concerted effort to stimulate and restore mentalizing and trust for the couple. The goal is not only to enable the couple to interrupt nonmentalizing and the vicious, nonmentalizing, coercive cycles to which it gives rise but also to help the partners use each other as resources to update and adapt their sense of themselves, the other, and the relationship. Promoting mentalizing serves to signal the possibility of trust, which in turn opens the relationship to joint attention, learning and exploration, mutual soothing, effective repair of misattunements, and the reciprocity that sustains in each partner a sense of coherence, hope, joy, and meaning. When both partners adopt a mentalizing stance, they create the possibility of virtuous cycles and the generalization of social learning to other relationships outside the couple that can serve to sustain the couple relationship. Achieving these goals is explicitly discussed with the couple when sharing the results of the formal assessment and through explicit education about the model in sessions. They are also presented implicitly, in the ongoing effort of the therapist to model a mentalizing stance (see below) and to promote such a stance in the couple.

Individual sessions are useful in the course of treatment at times of intense conflict and negativity in the sessions or in moments when treatment has reached an impasse. The individual sessions can allow each partner to better understand and address the sources of distress and prepare for the couple session by imagining and role playing their partner's perspective. Providing an experience of recognition and validation by the therapist may allow each partner to consider how to better understand their emotional reactions and role in the conflicts. It also allows partners to practice, via role play, how to communicate more effectively with each other, as well as to better understand how their partner may experience them.

In the case of a couple coming with different goals, such as one person wanting to preserve the marriage and heal the relationship and the other wanting to leave, or when either one is unsure about their commitment to the marriage, the goal remains to have each person understand their partner and themselves as a better basis for decision making and negotiating differences.

Process and Technical Aspects of Couple Therapy

Two core features make-up the process of MBT-CO: (1) the therapist's mentalizing stance, which guides the answer to the question "how to be?" in therapy (i.e., the skills and attitudes the therapist puts in practice), and (2) the spectrum of interventions, which helps determine "what to do?" or "where to be?" in the session on a moment-to-moment basis in deciding the level and focus of intervention. In the next section we describe specific competencies associated with successful mentalizing.

The Therapist's Mentalizing Stance

The therapist's mentalizing stance is arguably the fundamental component of all MBT protocols. It embodies the premise that the basic role of the therapist in MBT-CO (and all other MBT protocols) is to model the skills and attitudes that lead to effectively achieving two ongoing tasks in which the partners are invited to engage, including, first, to trust and learn in an attachment relationship and, second, to repair breakdowns in trust and mentalizing by pausing to consider one's own mind and being interested in understanding the mind and intentions of one's partner. The therapist's mentalizing stance provides a foundation for each partner to feel valued, respected, and understood by the therapist and, ultimately, by a context in which partners acquire a capacity to mentalize and trust themselves and each other.

Interventions that promote the safe environment that fosters attachment include ongoing efforts to encourage each person, including the therapist, to avoid or minimize talking over or interrupting, criticizing, blaming, or insulting. Safety is also promoted by the therapist's slowing down the flow of the conversation and by frequent checking to make sure that all parties accurately understand what each person is conveying, verbally and with their emotional tone and body posture. The therapist helps "warm things up" by inviting the partners to talk directly to each other when they appear detached or distant.

Conversely, the therapist asks the partners to speak directly to the therapist to help "cool things down" when one or both persons appear overwhelmed or dysregulated. The therapist then converses with one person at a time, while asking the other to listen carefully and to try to understand their partner without intervening. The MBT-CO process is a dynamic process of constant fluctuations in mentalizing and trust, of connections lost and gained. MBT-CO is designed to provide a container to process that fluidity and facilitate regaining balance.

MAINTAINING AN INQUISITIVE "NOT KNOWING" POSITION

The therapist affirms and seeks to demonstrate the value of the attitudes that express a mentalizing stance: authenticity, genuineness, respect, engagement, interest, curiosity, tentativeness, and a tolerance for not knowing, recognizing that each person and each couple has a unique perspective, history, culture, and background, and that the therapist's job is to be educated by the couple. Our success as therapists is dependent on our ability to learn. The therapist actively inquires about actions and behavior, as well as the feelings underneath, and invites each member of the couple to inquire about their partner's experience. There is a deliberate move to recognize behavior patterns that are troubling for the couple and, at the same time, to explore what underlies those behaviors. These inquiries are not fact-finding exercises but efforts to open conversations that track the details of each person's thoughts and feelings, and how those are impacted by the meaning they attribute to each other's communications.

An attitude of tolerance for not knowing helps to model that none of us can be certain what is in another person's mind and opens the capacity to entertain multiple perspectives. The therapist models that we can only access another person's experience if we are open to changing our minds as more information becomes available, and that we can be surprised by the information we acquire. In explaining "not knowing," the therapist can highlight when it happens in the session. Inquiring and then respecting, accepting, and validating—even if disagreeing with—each person's perspective serves to not only promote epistemic trust but also to model how partners can listen to each other with the intention of learning rather than debating.

HOLDING THE BALANCE

Effective mentalizing is manifested in a dynamic and flexible balance between attending to self and paying attention to the other, between affect and cognition and between automatic–mentalizing, which is facilitated by increasing stress and arousal, and controlled–mentalizing, which is more available when stress and arousal are reduced (Luyten, Malcorps, Fonagy, & Ensink, 2019). In addition, in MBT-CO, holding the balance involves ensuring that both persons can equally communicate their experience and feel heard and understood by their partner and the therapist.

The therapist invites a shift in perspective at a moment when affect dominates and appears overwhelming by helping the couple take a step back to carefully outline the sequence of interactions and experiences that led to the current state. Likewise, when cognition dominates, seemingly not grounded in feelings, the therapist invites the couple to recognize and name the emotions hidden at that moment, including consideration of bodily sensations that accompany certain mental states. Holding the balance also means striking a careful equilibrium between allowing the partners to interact naturally, eliciting habitual patterns, and actively intervening and suggesting alternative ways of interacting, particularly when impasses are reached and nonmentalizing dominates.

INTERRUPTING NONMENTALIZING

A basic premise of MBT-CO is that the emergence of nonmentalizing in the couple's interaction is a defensive response when the interaction has touched an area of vulnerability for one or both partners. Defensiveness and nonmentalizing in one person foster a breakdown of mentalizing and epistemic trust in the other person and activate self-perpetuating vicious cycles. The emergence of nonmentalizing in the session is a clear indication for the therapist to intervene. The first competence to practice in the face of nonmentalizing is the capacity to recognize it in the session, both for the couple and the therapist. Markers of nonmentalizing for the therapist include arguing with one or both partners, feeling certain of knowing the true meaning or intent of the couple's interactions, and losing the ability to maintain multiple perspectives. The second competence involves interrupting nonmentalizing in order to regain a mentalizing stance, the very process that the therapist seeks to promote in the partners' interactions. Strategies for regaining mentalizing include taking a moment's break in order to be able to pause and reflect on what has been happening both for the therapist and the couple.

The therapist's ability to recognize their own nonmentalizing and to seek to repair breakdowns demonstrates for the couple what to do when feeling stuck themselves. As we discuss later, pausing is often followed by an invitation to "rewind" to the moment before the communication became problematic. Pausing also makes it possible for the therapist to tease out the subjective experiences and interactions that render the partners unable to hear or understand either themselves or their partner.

The following is an example of a session in which the therapist is helping Robert and May, both previously married and very dedicated to their careers. Any issue involving money has been an immediate trigger for anger, hurt, and emotional withdrawal. May inherited some money from her parents, who had been extremely frugal and whose approval was always very important to her, whereas Robert has experienced a number of financial setbacks that have limited his earnings and made him dependent on May. Robert's father was chronically unemployed, struggled with alcohol addiction, and had difficulty supporting his family. Robert's own grown son and daughter have struggled to find steady work and are often in need of financial rescue. When Robert feels compelled to help them with rent or a car payment, May feels resentful and lashes out at Robert, who then becomes angry and critical of May.

Noticing this pattern, the therapist first suggests a pause to interrupt the cycle, then checks with both partners to see how they experience their conversation. The pause can be initiated by either party or the therapist, and it may involve simply taking 60–90 seconds to breathe deeply in silence followed by a question: "What was that like for you?" They feel like they are back in a rut that they can't escape but would like to find a way out. The therapist invites the partners to use a signal such as pushing an imaginary "pause button" or raising a hand when they feel they have reached an impasse or are feeling judged or criticized. Pressing a pause button serves to encourage awareness of one's own state of arousal while recognizing the need to check what is happening with one's partner. Inviting the couple to name the pattern of interaction, Robert and May now speak of the "money landmine field," which helps them take a bit of distance and acknowledge that this is a painful area that affects each of them in different ways. As the partners are able to be curious about their vulnerabilities and their shame regarding finances, the therapist observes them having a mentalizing conversation and notes their increased capacity for understanding themselves and each other as opposed to their previous efforts to cajole, argue, threaten, and otherwise coerce each other into agreement.

HIGHLIGHTING AND MARKING MENTALIZING

The therapist actively searches for instances of good mentalizing in the couple's interactions, marking when either partner shows evidence of being curious, respectful, interested in understanding the other's perspective, aware of the impact they have on the other, capable of disclosing vulnerable feelings without becoming defensive, and taking responsibility for their mistakes or misunderstandings and the hurt they cause. It may entail acknowledging worry that they have disappointed their partner in a way that feels unacceptable.

The Spectrum of Interventions

The spectrum of interventions provides the therapist with a road map for responding to the couple's level of mentalizing and defensiveness at any moment. The steps in the spectrum are support, empathy and validation; clarification; affect focus and affect elaboration; challenge and the therapeutic bargain; and repairing mentalizing and epistemic trust in the here and now of the relationship.

Following each intervention, the therapist monitors whether there is an enhancement in mentalizing and trust, and a corresponding decrease in defensiveness. This observation helps to recognize when to move to steps in the spectrum that require a greater capacity to mentalize and trust. On the other hand, a response that demonstrates less capacity for mentalizing and greater defensiveness suggests the need to further reduce the mentalizing demands on the couple. In this case, the therapist might use interventions such as "use of self." For example, the therapist takes responsibility for the failure to understand an interaction and the impact that the lack of understanding may have had on the couple, or the therapist may interview each person in the presence of the partner. The partner is then asked to listen without interrupting to see what can be learned.

EMPATHY, SUPPORT AND VALIDATION

The experience of feeling understood and that one is present in another person's mind is the essential condition that signals it is safe to trust. The step of empathy, support, and validation is thus the natural point of departure for all sessions and the point to return to when mentalizing breaks down and trust is eroded. Aiming to help regain mentalizing and trust, the therapist carefully questions each partner, seeking to elicit an account of their emotional experience. Respecting, understanding, and validating the perspective of one partner does not negate or invalidate the perspective of the other but helps both partners expand their perspectives. Understanding someone is not the same as agreement, and this is an important distinction. A response or reaction may be understandable given the beliefs held by the individual. The therapist can talk about "holding mind in mind," which is the ability to hold multiple perspectives and feelings at the same time. When able to hold multiple perspectives, both partners become more capable of experiencing their different perspectives not as "either–or" but more as "both–and."

In MBT-CO, the therapist does more than support, empathize, and validate each person's experience. This step involves promoting the ability of each person to stop invalidating the other and to hear their partner with an open heart and an open mind. Since the therapist is treating the relationship and the space between the two partners, they can also validate and empathize with both partners' efforts to have a functioning relationship and the challenges they face in trying to handle that space with compassion, kindness, and thoughtfulness. Facilitating such a position may require the therapist to have a supportive and empathic conversation with each partner in the presence of the other, who is asked to listen.

CLARIFICATION, AFFECT FOCUS, AND ELABORATION

Evidence of some degree of reflectiveness, curiosity, and openness to consider other perspectives is an indication to increase the mentalizing demands on the couple by pursuing clarification and elaboration. This step involves an effort to reconstruct the emotional and interpersonal context leading to breakdowns in mentalizing and epistemic trust, including a detailed picture of the feelings and the meanings given by each partner to the interactions leading to the disruption. Achieving this may include the use of "rewind and reflect," an approach in which the therapist asks the partners to track the last moment in which both felt that they could think and interact freely without confusion.

The therapist then engages in a "mentalizing chain analysis," establishing in great detail how mental states change as a result of the meaning each person assigns to a particular interaction. The therapist also attempts to expand and elaborate by seeking the hidden vulnerable feelings and meanings that typically lurk behind defensive, distancing affects. This more challenging intervention may also help couples to look at the impact of their own histories, either in their current families or in their families of origin.

For example, when Robert and May, mentioned earlier, were locked in battles of mutual resentment regarding "his irresponsible squandering of the assets" and "her demeaning, humiliating, and unsupportive stinginess," careful reflection helped May to recognize that she was afraid that she could only hold on to Robert because of her ability to buy out his interest, so she constantly felt that she would lose Robert if she didn't agree with him regarding finances. He, in turn, was able to help May understand, his desperate need to prove that he, unlike his father, is a caring and effective parent to his children and the enormous shame he feels when he is unable to provide for them. His fear of disappointing his children prevented him from having honest conversations with them about money. Requests were rarely denied regardless of the cost, even when it meant putting himself into debt. He also had great difficulty recognizing the differences between his situation and that of his father, and lived in terror that his children would feel about him the way he felt about his own father. Again, the therapist checks to ensure that both partners feel understood and experience a sense of ownership over the increasingly coherent narrative they are jointly constructing.

CHALLENGE AND THE THERAPEUTIC BARGAIN

The therapist is in a position to challenge the couple once there is a sense of enhanced collaboration, and the partners are working together and with the therapist. Paradoxically, it is also an approach designed to surprise the partners and jolt them back to a more reflective stance, particularly when there is a predominance of the pretend mode in their communication, in which they may be ignoring an important and sometimes damaging or dangerous behavior—for example, a partner's addictive behavior, infidelity, or undisclosed financial decisions or secrets that could put the family at risk. Typically, this challenge involves looking at the potential downsides of changing a behavior, even one that appears problematic.

The therapist may be quite explicit about moving into difficult territory, as in "I hope you will bear with me, but I think this is really important." Facing an uncomfortable experience of sharing vulnerability is difficult and requires skill. Paul and Helen came to therapy to address Paul's depression and the deterioration of their marriage after Paul learned that Helen had been having an affair. After overcoming his humiliation and despair upon finding out about his wife's affair, he decided to propose to her in the session that they seek to rebuild their shattered trust. Helen hesitated for a moment before answering, and Paul exploded in anger, accusing her of rejecting him again and certain that she felt only contempt for him. In the session, Helen said that she felt confused, guilty, and afraid of Paul's anger when he made his proposal, but this did little to soothe or calm Paul.

Only in a follow-up individual session could Paul acknowledge the panic he experienced when Helen hesitated and he felt certain that he did not matter to her as much as she mattered to him. These struggles and reactions that often accompany a step toward reconciliation illustrate an understandable reluctance to give up the protection afforded by defensiveness and nonmentalizing, in spite of the pain and limitations they produce. It is a moment to reflect on the courage that Paul needs to replace his anger and his conviction that Helen wants to hurt and reject him with the far riskier position of opening himself up by letting Helen know how much she means to him, then daring to check to see whether she cares enough about him to try to repair the relationship. The shift in paradigm often involves giving up the comfort of the certainty of failure for the uncertain outcome that may result from having hope.

This dilemma highlights the basic therapeutic bargain that treatment offers couples. The dilemma is to choose between holding on to defensive, nonmentalizing approaches that provide a semblance of control, safety, and protection on the one hand, and taking the risk of giving up those protections on the other, in order to trust another person, knowing that, while there is no certainty, there is the possibility of learning how to attain real mastery and genuine reciprocity.

REPAIRING MENTALIZING AND EPISTEMIC TRUST IN THE HERE AND NOW

The greatest mentalizing demand is to expose our vulnerabilities to each other and to maintain trust and mentalizing in the face of intense emotions. The greatest chance for the partners to build resiliencies is to provide a safe haven and a secure base for each other in which epistemic trust and social learning can flourish. This capacity to repair offers each person the best chance to acquire a set of tools that can be generalized to other relationships outside of the couple, and to other contexts outside the treatment relationship, reinstating the resilience-enhancing possibilities of social learning.

The therapist's readiness to take responsibility for mistakes and misattunements, and the pain they cause, sets the stage for a different kind of interaction. We are holding ourselves to be accountable in the relationship in a way that is parallel to what we hope for with the couples we treat. Apologizing to the couple and encouraging them to initiate this crucial step within their relationship opens the door to greater intimacy.

In listening with an open heart and a calm and inquisitive mind, we practice not interrupting or justifying ourselves, not trying to solve the problem or change the other person's mind, but only to seek to understand and recognize each partner's experience. It is often helpful to educate couples about the rules of effective apology (Lerner, 2017). In encouraging apologies, the therapist highlights that repairing requires first the capacity to take responsibility, not for the other person's feelings but for one's own hurtful actions. In order to take responsibility, we have to be interested in and then be willing to learn our partner's perspective and tolerate the fact that we inevitably fall short of our partner's needs and wishes and will likely disappoint our partners no matter how hard we try. We as therapists also invite the partners we work with to maintain a mentalizing stance even when the other person is not able to accept the apology or reverts to defensiveness or hostility.

CURATIVE FACTORS/MECHANISMS OF CHANGE

From this vantage point, we come to the rather bold proposal that the key "active ingredient," the basic healing mechanism of therapy—whether it is MBT-CO or any modality of psychosocial intervention—is the establishment of a relationship in which people feel understood and are helped to understand themselves and others, which mobilizes epistemic trust, social learning, and symbolic/representational processing. The curative factor of MBT-CO is the achievement of robust "relational mentalizing," which refers to shared thinking and feeling within a couple or other group. We assume that well-functioning couple relationships share intentionality and occupy a shared mental space. While thoughts and feelings about relationships are usually appropriately addressed in relation to mentalizing about others or mentalizing about the self in relation to others, there is a higher level of interactive process that we must address. These concern intentional states that are assumed by individuals in the system to be joint or shared by everyone. Tuomela (2005) has evocatively named this category "jointly seeing to it" (JSTIT). It has been argued that mentalizing has a somewhat special "we-mode" (Gallotti & Frith, 2013). To put it plainly, other people being around makes one think differently and better. This involves co-representing the other's viewpoint, a precondition for joint action.

The convergence of mentalizing increases our confidence in our imagined inferences about the inner states of others. But perhaps most significantly, it contributes to the formation and maintenance of emotional bonds. In other words, we assume that relational mentalizing, in and of itself, acts as a catalyst to (re)create links of affection in the couple.

Co-mentalizing or relational mentalizing concerns thoughts and feelings that drive options for doing things that one could not do on one's own. When people decide to act together, to join forces, there is a sense in which no members of the group can be assumed to be doing it "on their own" or can be appropriately considered as thinking or feeling in isolation from others in that psychological collective. The we-mode is an experience that forms the basis for cooperation, commitment to shared goals, and catalyzes the development of epistemic trust and trustworthiness (Tuomela, 2005). We suggest that its recovery (or, indeed, its establishment) is the fundamental mechanism of change in couple therapy when the underlying problem is the loss of shared intentionality. The experience of the we-mode is normally a mutual creation by the couple. It naturally comes and goes, lost in noncooperative interactions and restored continually in the cultivation of epistemic trust.

Here we summarize the key features we believe may be most important to generate shared intentionality of relational and co-mentalizing:

1. Joint intentions: When intentions are joined up, the couple is working in the we-mode. Developing such shared perspectives is at the heart of relational or co-mentalizing. While explicit awareness of a nonshared nature of joint intentions paradoxically makes for a strong we-mode, assuming a we-mode in a manner that is actually far from joint is quite common in troubled couple relationships, and declaring intentions to be joint is a frequent indicator of its direct opposite. Addressing assumptions about joint actions that are grossly inaccurate and self-serving is a key part of the process of change.

2. Beyond manifesting shared or joint intentions, the acceptance of an emerging, fresh joint perspective is best indicated by joint action on the part of the couple. If partners initiate a plan, then act as a coherent unit, with both members actively participating in joint intentional action, we may talk about effective co-mentalizing. This is not a complex process, but it needs to involve genuinely joint actions. Physically being engaged in joint action is not sufficient for change—it is a shared experience of engagement (e.g., jointly overcoming barriers to achieve the activity) that drives the process in which the "I-mode" is voluntarily subsumed into one in which the dominant goal is joint action and collaboration.

3. Developing communication skills for sharing intentions. A movement toward a relational not-knowing stance (inquisitiveness and curiosity about each other's mental states) mostly implicitly rather than explicitly evolves and can foster the potential for developing relationships and open exchanges of thoughts and feelings. The expansion of effort to see the other's internal state and perspective can enable the other(s) to feel "seen" and oneself to feel "seen." Furthermore, developing comfort in collaborating requires the capacity to check in with each other; to discuss thoughts, feelings, hopes, and plans with each other; and to guarantee a time when this can occur.

4. Measured (nonparanoid) trusting responsiveness generates a benign background for relational mentalizing. Acknowledging, in one's reaction, the potential for making unfounded assumptions when interpreting others' social actions can help to facilitate joint action.

5. Creating a setting for turn taking establishes the essential give-and-take in interactions with others and provides evidence in real time of effective mentalizing (e.g., the need to make oneself available for being understood and to engage in extending one's understanding by taking on board the other person's thoughts and preoccupations).

6. Relational impact awareness implies the appreciation of how one's own thoughts, feelings, and actions affect the relationship. It essentially denotes the acknowledgment of personal agency (the impact one has) on the relational context.

7. Joint playfulness as a shared state of mind can also be a key change mechanism, as it permits transgressing the physically palpable world "out there" and entering the arena of "make believe," opening up the mind to collective experimentation and imagination. Joining with a partner in playful exploration of mutual understandings and feelings can indicate effective co-mentalizing. Playfulness and the use of humor enables lifting some of the inhibitions that can prevent a couple from arriving at shared intentionality. For

example, the vulnerability of the other's sense of self can block arriving at a shared experience in the family but engaging in play may reduce self-consciousness sufficiently for a community of minds to be formed.

8. The joint belief in changeability established in the formulation and the therapeutic bargain ushers in a view of causation not just from a physical (psychic equivalent and teleological) level but from a more nuanced psychological level. The core assumption of the MBT-CO approach that "minds can change minds" can imbue partners with a sense of optimism, of "never giving up" while working together. In this context, "changeability" refers to the couple's shared experience of optimism in relation to JSTIT ("jointly seeing to it"; Tuomela, 2005): "We had difficult situations before and we have dealt with them; we are not sure what the solution is this time, but we will sort it out somehow."

9. MBT-CO focuses on the relationship rather than the individuals in the relationship because it assumes that the growing capacity to trust in the relationship is most likely to be the key to successful treatment. Beyond trust within the dyadic attachments, which is primarily driven by responsiveness, here we are concerned with a systemic sense of trust ("Will this relationship deliver for me?"), which may be a vital ingredient for forming and sustaining a meaningful connection. Attachment to an individual may be quite different from an overarching sense of trust in the relationship with that individual. Love for that person does not preclude having no faith in the relationship. Trust in the relationship signifies the return of the we-mode and may be the basic driver of change.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

The theoretical and clinical ideas advanced in this chapter are relatively well supported by empirical findings (Luyten, Campbell, Allison, & Fonagy, 2020). Mentalizing has been shown to have both trait (some individuals mentalize better than others) and state features (at some moments, and in some situations, we may mentalize ineffectively); it is to a large extent relationship-specific, and controlled mentalizing tends to be inhibited with increasing arousal or stress (Luyten et al., 2019). The core assumption of the theory, namely, that parental mentalizing of infants, treating them as psychological agents, is known to be conducive to the development of secure attachment in children (Zeegers, Colonessi, Stams, & Meins, 2017). Studies also suggest that cognitive features of mentalizing, including joint attention, perspective taking, and theory of mind, as well as affective components, such as emotion processing, empathy, and the use of mental-state language, are more marked in securely attached children (Kobak, Zajac, Abbott, Zisk, & Bounoua, 2017) and adults (Troyer & Greitemeyer, 2018). Studies also support the assumption that higher levels of parental mentalizing foster mentalizing in children and adolescents (Rosso & Airaldi, 2016). Early adversity severely impairs mentalizing, as indicated by strongly biased mentalizing, hypersensitivity to the mental states of others, a defensive inhibition of mentalizing, or a combination of these features (for a review, see Borelli et al., 2019). There is also evidence that high levels of caregivers' reflective functioning, and specifically reflective functioning with regard to their own traumatic experiences, may be an important buffer in the relationship between early adversity and child outcomes (Ensink, Begin, Normandin, & Fonagy, 2017). MBT-CO assumes that both attachment and mentalizing play key roles in stress and arousal regulation, and neuroscience studies have generally supported the assumption of associations among attachment dimensions, mentalizing, and stress and arousal regulation (for reviews, see Feldman, 2021).

CASE ILLUSTRATION

Elena, 35, and Alec, 37, came to couple therapy, referred by a friend. They had separated several times and were not sure whether they wanted to remain together. They had been married for 11 years and had two sons, Carlos, 7, and Thomas, 5. Elena grew up with her parents and a younger brother in a small town in northern Mexico. She was a bright, enterprising student during high school and was educated at the Technological Institute of Monterrey. Following her junior year of college, she came to the United States after obtaining an internship at a university in Houston.

Alec grew up in Ft. Worth with an older sister and a younger brother. He had been an average student at his high school, but early on he had demonstrated a keen interest in computers and data analysis. He began college in Texas but dropped out after 2 years to start a company that designed software programs.

Alec met Elena when giving a presentation to her class about employment opportunities at his company. In their shared narrative of the start of their relationship, Alec was instantly captivated by Elena, thinking that she was beautiful and unlike anyone he had known before. He particularly appreciated her sophisticated questions, poise, and confidence. Meanwhile, Elena thought Alec was exceptionally smart and liked that he was also a little reserved and not showy. They quickly became a couple and moved in together after 6 months in what was the first live-in relationship for both of them. While living together, Elena obtained a master's degree and Alec worked on building his company.

The early years of their relationship were rather idyllic for both of them. They were involved in jobs that they found satisfying and happily worked long hours. Alec's business began to grow, and upon graduation, Elena was hired as a web designer for a large architectural firm.

Alec made the initial call requesting couple therapy but was unsure whether Elena would be willing to attend. He asked to meet individually before the first couple session. The therapist suggested that he ask Elena to join him for the first session, explaining to him that in MBT-CO, as in many other couple therapies, it is standard procedure to see the couple together initially to start off on an equal footing and to be able to understand and review their perspectives and intentions.

Coming to the first session, Elena, a tall, rather striking woman, wore her thick black hair in a long braid. She was stylishly dressed in a long skirt and tailored blouse, and appeared sad and reluctant to make eye contact. Alec, a few inches shorter than his wife, had a muscular build. He was casually dressed in jeans and a T-shirt, with a neatly trimmed beard, glasses, and long sandy-colored hair. While they walked beside each other, they maintained a distance between them that they kept after they sat on the sofa.

First Joint Interview

As described earlier, the first session is designed to develop an alliance with each partner by fostering in both the experience of feeling heard, recognized, and understood by the therapist, and, as much as possible, by each other. The initial session also serves to explore the couple's goals in seeking consultation and to explain the assessment process. The therapist began with introductions and asked them what led them to this point, and what each of them had in their minds in coming to the session.

ALEC: Elena knows I was the one who called. I'm worried that we fight all the time. I don't think that's good for the boys or for us, and it's been going on now for 5 years. We were so happy, and now we are in so much trouble. I think Elena hates me and doesn't respect me. Lately, I know, I've been pretty miserable, and sometimes I don't want to come home from work. I don't want to keep living this way, and I thought we should try something. I don't think it can get much worse.

ELENA: I know that I'm angry all the time. I feel like Alec is gone, from me and from the boys, and I feel like I carry all the burden of the family. I never expected it would be like this. I worked hard to have a career, and I thought we would be a team, but that's gone. Alec is right, I can't look at him without feeling anger and we've gotten to the point our interactions get ugly pretty quickly.

THERAPIST: So you both have been really unhappy with how things are, for yourselves and for your marriage. It makes sense to me that you are wanting to get help, and I'm glad you made the call. It sounds like you were both willing to come to see whether things could be better.

ALEC: That's true for me, but I worry about whether this is something that Elena wants.

THERAPIST: That's important. Could you ask her if she shares your desire for things to be better for the two of you? (*Alec nods and asks Elena.*)

[The therapist looks for opportunities to encourage partners' mutual checking of each other's perspective, thoughts, and feelings.]

ELENA: I haven't known if you really have any interest in making things better or if you just want to retreat, maybe stay married and miserable or maybe want to leave. I don't want to lose you or our family, but I've been angry and upset, and I want something different, too. We have given up on even trying to talk to each other. (*Alec nods in agreement.*)

THERAPIST: Would it be okay if we use this time to do what you say you have kind of given up on doing? Talking with each other to see if you can learn more about how the other feels and then understanding what has happened that has made you feel like giving up?

They both date the start of more significant marital strain to the birth of their younger son, Thomas. After Carlos's birth 2 years earlier, Elena had decided to leave her job and work half-time, taking on independent projects, so she could spend more time with Carlos. She was happy about her decision and felt supported by Alec. He worked more than she would have liked but still carved out time for them to be together as a family. At the same time, Alec became more concerned about finances and more distressed about Elena's spending, while she got upset about his extravagant technology purchases. When Carlos turned 1, Elena began talking about having a second child. Before their engagement, they had talked about wanting a large family with several children. But now that they were married and had a child, Alec felt increasingly overwhelmed by the demands of work, home, and his parents, who wanted more of his time after his father developed health problems.

This dilemma about whether to have a second child became a central sticking point, one that seemed emblematic of their difficulty in handling conflict. Elena felt that Alec had betrayed her when he changed his position and no longer wanted more children, and she couldn't bear the thought of Carlos growing up without a sibling. She was also angry at Alec for putting her in a position where she either had to make him do something he didn't want, which would make him withdraw from her, or give up on something important to her, which would make her resentful. Alec felt like he was faced with an ultimatum: Either prepare for a second child, which felt impossible to him, or lose Elena, not necessarily through divorce or separation but through disappointment and loss of faith in him. Alec reluctantly capitulated. Sexual intimacy fell hostage to Elena's anger and Alec's concern that Elena might "trick him" in order to get pregnant. Their trust in each other evaporated, and the stalemate began to expose other fissures in their relationship.

To explore this highly charged stalemate and the associated loss of mentalizing and trust in the couple, the therapist interviewed each partner in front of the other. They took turns discussing their current level of trust and attunement, including the degree to which they felt seen by each other, their current capacity for collaboration, and their ability to see more than one perspective. The therapist invited them to consider what they valued in their partner that they would not want to change (or even the areas that they had valued in the past). Particular attention is paid in MBT-CO to how these broad themes of conflict and stalemate reverberate in the routines of partners' daily life, their ability to collaborate, their experiences of sexual intimacy, their capacity to take responsibility and repair, and their hopes for moving forward.

Toward the end of the first meeting, the therapist asked Alec and Elena about their goals for therapy. "If we decide to work together and things go as well as they can, how would you like your relationship to look 6 months from now?" Elena hoped they could forgive each other for the pain they have caused and enjoy doing things together again. She wanted to be less angry and resentful. She knew that she was highly critical and expected Alec to be unhappy with her and then would jump on every instance when she felt dismissed. Alec wanted to come home without having a knot in his stomach and wanted to do a better job as a dad. He wanted to be able to take a break when he got upset instead of going into "lockdown," where he was unreachable, and he wanted Elena to understand that he sometimes needs space to calm down without her coming after him. Alec suggests an awareness of his loss of mentalizing (going into "lockdown") and the impact Elena has had on his own defensiveness. Elena, in turn, appreciates how her anger and criticism have led Alec to distance and dismiss her, and she is beginning to recognize how much she feels angry and upset, alone, and abandoned, with no place to process her feelings. She worries that perhaps Alec doesn't care. The therapist marks these instances of spontaneous mentalizing and notices their ability to recognize each other's perspective and the impact they have on each other.

Individual Interview with Alec

Alec was relieved to know that Elena also wanted to repair some things in their relationship, which came as a welcome surprise to him. His family had been opposed to their marriage and had been critical of Elena. She wanted to get married much sooner than Alec, and they were suspicious of her intentions, wondering if part of her attraction was the promise of citizenship. The accusation infuriated Alec, but he was reluctant to challenge his family. He continued, instead, to try to balance loyalty to his family with loyalty to Elena, usually failing on both fronts.

Over the last 2 years, they had struggled to make time to be together. Alec readily admitted avoiding being alone with Elena, as he expected that when alone together, she would criticize him for not being present, missing the irony that in avoiding being present to spare himself being criticized for his absence, he participated in a cycle in which his absence exacerbated Elena's criticism. Sexual intimacy, which was once a source of joy to them, was now largely absent, and Alec felt unsure whether Elena found him appealing. He had taken to watching pornography but found this unsatisfying, depressing, and shameful. He had also been smoking pot daily and avoided sharing with Elena the extent of his use. At work, he snorted cocaine with colleagues. He felt that he needed help to talk with Elena about his drug use, afraid that he couldn't handle her reaction to this disclosure. He denied any affairs but was aware that he would be at risk if the marital situation did not improve.

The harshest fights and disagreements they had were about the children and their basic lack of trust in each other's intentions. Alec felt that Elena was contemptuous of him, his job, and his parenting. "She says I live in my own world and never pay attention. When she gets really angry, she says that she would be better off as a single parent rather than trying to work things out with me. It makes me so angry, especially when I see her yelling or cursing at them and they come to me crying. Then she tells me it's all my fault, that I'm just like my father, or whatever she can throw at me. Sometimes I just leave or sometimes she gets mad enough and she leaves. It's not good and pretty unstable for the boys. I've taken videos of her when she is really out of control to show her how badly she behaves."

The therapist is concerned to hear that Alec is taking videos of his wife and responds by asking what he imagined that was like for Elena rather than first finding out what was going on for him. The therapist recognizes trying to get Alec to mentalize his wife before first understanding Alec and takes a step back: "You know before going there, I want to understand what this was like for you. I wanted to check with you about how you were feeling when you got the camera."

ALEC: I felt awful to see that happening and the kids crying. It was terrible. I wanted to prove to her that she shouldn't do that, and I felt like it was the only thing I could do. I felt powerless and that I had to do something.

THERAPIST: I can understand how upsetting it was for you. I also wondered if you had an idea about what it might have felt like to her to see you recording her and the boys?

ALEC: Well, she may have been upset, but I wanted to show her that I'm not the only one with a problem.

THERAPIST: I get it. [The response to psychic equivalence is to empathize and validate before offering an alternative perspective, which can be difficult for the therapist in the face of harmful behavior.] Did you think there might be a way to talk to Elena about what happened and understand better what was going on that got her so upset with the boys and later with you?

ALEC: I didn't think she would listen or care. I honestly didn't care what it was like for her. I was just mad.

THERAPIST: So that's a really important issue for us to address.

ALEC: Yeah. She was furious and told me she knew I was doing this to divorce her and file for custody. When Elena was in Mexico most recently, she was still upset with me about the videos and not being present, and she threatened to stay in Mexico with the boys and not return home. I was really pissed and scared and called a lawyer because I couldn't think of any other way that she would hear how much I wanted her to come home. Now I get why she was upset but at the time I thought I was doing the right thing.

The therapist noticed that as Alec felt understood, he was able to expand the exploration of his feelings to include his fear of losing his children and his helplessness in being unable to have an impact on Elena. As he explored these feelings, he was able to shift from the more coercive stance of video recording, "showing her," threatening and calling lawyers to a more reflective stance of concern and a desire to understand what may have been going on for both of them.

THERAPIST: As I hear you talk about the feelings you had underneath your anger, I wonder if we could unpack a bit what goes on between you and Elena when you two fight. Can we look, let's say, at the last time you had a fight?

ALEC: Sure. Last week, Elena was trying to get Thomas to put his shoes on while she was making breakfast. He started screaming and threw his shoe at her. Elena had been out late the night before with some friends and had come home at 2:00 A.M., so I was pretty angry with her anyway and wondered what she had been doing. That's not really like her. Anyway, I'd been worried about her and couldn't sleep, and when she did come home, she went in the other room to go to bed and never came in to talk to me. I decided to stay in bed and didn't get up to make lunches like I usually do, and Elena started cursing and yelling at me for lying around and doing nothing. I was still upset with her about the night before, but she wouldn't even talk to me about it. We still haven't talked about what happened.

Therapist: What was it like for you when she didn't come home?

Alec: I got upset and angry, and felt like she was trying to get back at me.

Therapist: I can understand that. Did you have any idea about what might have prompted her to stay out without telling you?

Alec: I really don't know. She wanted me to go with her that weekend to see her mother, who was sad after recently losing a close friend. I couldn't go; I had plans at work that I couldn't change, but she didn't believe me. She also had been more upset lately about me smoking pot because she thinks I check out even more when I do.

Therapist: What was it like for you when Elena wanted you to go to Mexico with her?

Alec: I felt like I never have a chance to do things I need to do, and I knew she would never understand, so I just said no.

Alec's ability to hold onto a mentalizing attitude in relation to Elena appears tenuous. The following illustrates these fluctuations in mentalizing as the therapist seeks to assess Alec's mentalizing strengths and challenges Alec after he describes his flat refusal to consider a request from Elena.

Therapist: What do you imagine it might have been like for her when you said "no"?

Alec: She yelled at me and said she knows I don't care about her. She also threw in that I'd rather stay around here and get stoned and check out with my buddies than do something for her. That seemed so unfair, and I told her that all she ever does is criticize me for what I don't do and act like I'm the worst person in the world. I'm sick of being blamed every time I can't do exactly what she wants.

Therapist: What do you make of her observation about wanting to get stoned and check out?

Alec: Maybe. It's true that pot helps me calm down and not be so anxious, and I also kind of get in my own space and don't pay as much attention to what's going on.

Therapist: Have you talked about that with Elena?

Alec: Not exactly.

Therapist: Is that something we can look at when we get back together?

Alec: If you think it would help. I'm feeling pretty desperate.

Therapist: I really appreciate how desperate it all feels. Trying to figure out how you got to this place, I wondered about the time the desperation began to creep into your marriage, which both of you seem to agree was at the time of thinking about having a second child. I wonder if you can tell me a little more about what it has meant to you to have another child?

Alec: I just had this feeling in my gut that it would take us over an edge.

Therapist: Any idea about what gave you that feeling? That sense that a second child would take you over the edge?

Alec: Well maybe. My younger brother was a real problem for my parents. He was way hyperactive as a kid and was always in trouble at school. I think he got kicked out of high school. I'm not sure why, and he doesn't have much contact with the family. We've never been close, and I never really thought what happened to him affected me very much.

Therapist: Any thoughts or feelings you have about that now?

Alec: Well, it's a lot to think about. I have been really unhappy, and I think I do a lot of things to protect myself or take my mind off how hard this marriage is and whether it's worth it.

Therapist: That's a good segue into a question I often ask. If you were to rate yourself on a scale of 1–10, with 1 being that you would leave this office to consult with an attorney about divorce and 10 being that you would never leave this marriage, no matter what, what number would you give yourself?

Alec: Seven.

Therapist: And what number do you think Elena would give herself?

Alec: Three.

Individual Interview with Elena

Elena found the first meeting helpful, since she imagined that Alec was setting up this meeting as a prelude to divorce. She has always felt like she had to talk Alec into taking each step in furthering his commitment, first moving in with each other, then getting married, then having a child, and then having a second child. On reflection, she could get a little curious about why she was willing to keep working so hard with someone who was so reluctant. She clearly wanted a different kind of life for herself than her parents and thought that a life with Alec made her goal reachable, even if she had to take the lead. Alec had seemed happy taking each new step toward commitment, with the exception of their decision to have a second child.

Elena: I think the fights are a lot worse than we let on in our first session. I have left the house several times in the last 6 months, sometimes taking the boys with me and sometimes, when Alec seems okay, leaving them there. I take the boys with me if he has been using pot. I know he has also used cocaine pretty regularly, though I don't think he knows that I know. He accused me of drinking too much, and maybe he's right. Recently, he has started taking videos of me and the boys when I get upset, and I am beyond furious. When I went to Mexico most recently, after he had been working nonstop for days, I told him I might as well stay in Mexico with the boys and enroll them in school there. I was so angry with him that I thought I would actually do that. He called a lawyer to pull a power play and make us return. Later, he tried to call and tell me he was sorry, and we came back, but things are still pretty tense.

As the session unfolds, the therapist begins to probe Elena's capacity to "see herself from the outside," from Alec's perspective, and from a position of awareness of the impact she has on him and on their family. In exploring her drinking, the therapist asks how she imagines Alec may experience it.

Elena: I think he worries about something happening to the boys or me being spacey if I drink too much. He's not happy about it, but he can't say much given his own drug use.

Therapist: So he worries but cannot say much about it. I wonder how that predicament comes out.

Elena: I think we get into fights, even physical ones. Once he grabbed me as I was trying to leave the house. It made me furious and I reached back to hit him. I think we both realized that we needed to get away from each other. One other time, we were fighting and he went downstairs to take a break. I went after him and wouldn't leave the room, and he pushed me out the door and slammed it in my face.

Therapist: What usually happens after one of those fights?

Elena: Usually nothing. We get up the next day and go on as if nothing happened. But I don't think that's healthy either.

Therapist: How safe do you feel with Alec now?

Elena: This happened some months ago, and I think it is also why he wanted us to see someone for therapy. Neither of us want to keep doing things that feel awful afterward.

Therapist: How do you understand what happened for the two of you? How things got so off track.

Elena: I think the fight about another baby just brought up all the other ways we don't agree about important things. I really don't think Alec cares much about how I feel, and I don't want to have to put in all the effort to make things better if he isn't trying.

Therapist: That's a hard spot to be in. I wonder at the same time how much do you think Alec feels like you "get" him.

Elena: Probably not very much. And right now, I don't get him. I don't understand how he does the things he does, and I still haven't ever understood his deal about having Thomas.

Therapist: Can you help me know more about what having a second child meant to you?

Elena: Alec knows this. I had an abortion when I was in college. My parents don't know, my brother doesn't know. Only one friend and Alec know. The guy I was with wasn't even someone I had a relationship with, and he has no idea. I was very clear about ending the pregnancy, but it left me feeling that one day I would have my own children who were very much wanted, and that would help make up for the loss. It probably doesn't sound completely rational, but it has helped me to have this plan.

Therapist: So I understand that each of you may have had more complex feelings about this decision. How do you let him know about these complicated feelings of loss and sadness and hope that you have?

Elena: I don't. We don't talk. Alec argues and tries to prove why he is right. It can get pretty heated. I hate when I feel disrespected, so I get louder until I feel heard and I won't stop.

Therapist: How has it been for you having this conversation today?

Elena: I feel a little more hopeful. I remember a time when I really loved Alec. When he's "on," he can be a really good dad, not like his father, irritated and impatient; he can be playful and sweet with them, and he can even help them calm down. It's just been so bad lately that I've thought we would do less damage to the boys if we separated.

Therapist: And now?

Elena: Not so sure.

Therapist: I want to ask you the same question I asked Alec about your commitment to the marriage today. If 1 is that you are leaving here to file for divorce and 10 is that you can't imagine leaving, no matter what, what number would you give yourself?

Elena: Seven.

Therapist: And what number do you think Alec would give himself?

Elena: Four.

Joint Session with Elena and Alec

Alec and Elena reported going out on a date together which was unusual for them. They had also spent some time together in the evenings after they had put the boys to bed. They had been more deliberate about planning their schedules to make sure each one did his or her part, and they had the opportunity to process their day with each other. Elena was still worried about Alec's use of pot as a way to manage his feelings, and Alec came back quickly, criticizing Elena's nightly glasses of wine. They were eager to know about the assessment and looked nervously at each other.

Therapist: I want to begin by talking about what I understand at this point about the strengths that you have individually and as a couple, the challenges I think you face, and my recommendations going forward. Okay to start? (*Both nod.*) Your relationship was built on a strong foundation of mutual attraction and respect, and a sense that you really complemented each other. I believe that both of you are quite committed to your marriage. But it seems to me that you are not quite sure that you can express that commitment out of a concern that the other may not be quite as committed as you are. I was struck by how much anxiety and hurt each of you must have felt thinking that you and your marriage did not matter to your partner as much as they mattered to you. Let me pause here and see how this feels to each of you. What I have right, what might not be the way you see it, or anything I have left out.

Elena: I appreciate what you are saying and I think it's right. I've been really stressed and scared that, Alec, you don't really want this relationship.

Alec: When I brought up couple therapy and you didn't want to come, I figured we were really in trouble, so this makes me feel better. I've been feeling like you gave up on me, and then I've been kind of hiding out. It sounds like you think there's hope.

Therapist: I think there is a lot of hope. It also seems like there have been some challenges that you haven't really been able to recognize or talk about, though they absolutely affect each of you and your marriage. I can put them into several categories. The first is the conflict that really brought you here, which is the dilemma about having a second child. It seems to me that you got very quickly polarized, with each of you having a very strong sense of what was right for you and for your family. Unfortunately, it was really hard to look at what was driving the intensity of your positions, so each of you felt alone and angry. I don't know that either of you have been able to reflect on how vulnerable you felt when your partner could not understand your point of view or what some of the drivers have been underneath this issue. The second is the issue of intimacy and connection, as well as the capacity to stop and listen to each other when there is conflict. From the way you describe things, it sounds like, Alec, you sort of vacate the premises and avoid anything that might be confrontational; thus, the struggle about this decision about having another child. Elena, it sounds like you want to address the difficulties head on and get increasingly upset and frustrated when you can't talk about something that troubles you. These are both familiar coping strategies, but when they get going they can create a vicious cycle where, Alec, the more you avoid conflict, the more angry and critical Elena becomes, and Elena, the more you try to express your frustration to Alec, the more distant he becomes.

> The third is that both of you have been using substances to deal with your feelings in a way that makes you less available to each other. You turn to substances for soothing and comfort, and they become the most reliable attachments. They may help in the moment and are at least readily available, but they are often a poor substitute for human connection and security. And the last is your families of origin. I think that all marriages are bicultural, but I think yours is more explicitly so. What you have in common is that both families care deeply about you. On the other hand, both of you feel different degrees of responsibility to your families, which is not always easy to balance. Elena, you have come to a very different world than the world you grew up in. It's important for you that the boys speak Spanish and know their grandparents, and earlier, I think, Alec, you really understood this and made genuine efforts to support Elena's travel to be with her family. However, Alec, as you have faced more pushback from your parents and as your father has had his own health issues, I think that balance between your loyalty to the family you come from and your loyalty to Elena has been more difficult to navigate. I also think it has been especially difficult to have thoughtful conversations about the stress this situation creates for both of you. So let me pause and get feedback from you both on how these ideas fit with how you see yourselves.

Intermediate Sessions

Alec and Elena regularly attended sessions. They were able to listen carefully to each other as they understood the meaning that having a second child had for both of them. They became more compassionate and understanding of their own and each other's positions and took accountability for how they had treated each other in ways that caused pain. Drug and alcohol use remained problematic. Alec had not stopped using pot, and this continued to be a major stress for Elena, who also worried about how it could affect his capacity to be present for her and for their sons. Elena had cut down on drinking, but Alec still thought she drank in a way that kept her distant from him. The therapist continued to inquire about their relationship with drugs and alcohol, as well as how they imagined their drug or alcohol use affected the other members of the family. They accepted referrals to a program that would address substance abuse, but this remained an ongoing concern and unresolved until much later in the treatment.

Most of the sessions were joint, but during the ongoing work, there were occasionally times when individual sessions proved helpful. This was true at times of a predominance of psychic equivalence ("If I think or feel it, that is the truth") or teleological thinking ("If my partner does *this*, it means they don't care about me, my needs don't matter, my partner is selfish, unreliable"). Without having a way to have a conversation, these experiences became fixed beliefs in the marriage, and the couple's problematic patterns became more entrenched. Occasionally, they would use individual sessions as a way to get clear on how to handle a difficult conversation, practicing how to communicate their own wants and needs more effectively.

Alec was more active with the boys, but he would feel very hurt and embarrassed when they were more difficult and would expect Elena to be critical. Initially, Elena was critical, and Alec would show defensiveness and anger after dropping Carlos at school. He would return, ashamed when Carlos didn't behave properly, and easily felt blamed and humiliated by Elena. Over time, he was able to be more honest with her about his own wish for appreciation and approval, and she was able to be more understanding and supportive as he began to take on a more active parenting role, a role that was not really familiar to him with his own father. Alec was then able to talk to Elena about his insecurity as a father, and Elena began to see him as an ally and a partner rather than an adversary.

After a year, there was another crisis when Elena's mother's health deteriorated and Elena wanted to spend the next school year with her family in Mexico. She wanted the boys to attend school there and become fluent Spanish speakers. Alec was frightened at the prospect and fearful, as he was a year earlier, of losing his sons. Even though their relationship was markedly better, there were still challenges. Alec had finally reduced the frequency of his use of pot and no longer used cocaine, and Elena cut back on drinking, though each was at risk of using substances at times of stress with each other. The use of the video camera was no longer an issue, and when they fought, they no longer threatened divorce. Sexual intimacy was an important focus. They had a difficult time negotiating desire. Alec still got upset when he wanted to have sex and Elena did not, and Elena would get upset when Alec slept in a separate bedroom when she wanted to cuddle with him in bed. They both got better at being able to talk about longings and desires without being coercive or avoidant.

In the therapy, there was a great deal of discussion about what a temporary move to Mexico would mean for all of them. It became clear to both Alec and Elena that this was an important opportunity to see if they could really embrace a we-mode that required a genuine commitment to joint action and intentionality. Alec was now quite connected with the boys and was not comfortable with an extended separation. He also wanted to be available to his family. His father's health had improved, but his parents still wanted more of his time. He had been more direct with them about their treatment of Elena and how he hoped they could support him by reaching out to her. They made efforts to reach out to Elena, and their relationship had improved but it was still painful for Elena.

Sessions now began with Alec and Elena telling the therapist how they imagined their spouse experienced them since the last session. The focus shifted to the ways they not only intended to support each other, but also their curiosity about how well they were doing in both actions and intentions, as well as their capacity to live with a balance of individual interests and a fundamental commitment to working in a we-mode. Interestingly, the process they went through in making their decision about how to handle spending time as a family in Mexico set the stage for their ability to both plan together and to care about each other's needs. As the work progressed the sessions moved from weekly to biweekly.

They decided to move to Mexico for the school's fall semester, with plans to visit Houston for Thanksgiving and to move back before Christmas. This would involve Alec traveling, but he felt that this could be an enriching experience for their family as they planned adventures with their sons in the areas around Elena's hometown. We agreed to have monthly video sessions during the fall semester and met once after they returned. They also had developed a more compassionate and humble view of marriage and grew to see the inevitable struggles as part of life rather than a marker of some greater deficit or personal failure.

CONCLUDING COMMENTS

Most obviously, MBT-CO requires rigorous testing to establish its effectiveness, not only generally but also in comparison to other approaches, and in particular, to better delineate which couples under which conditions, struggling with what kind of problems, benefit the most from what kinds of interventions. It is our contention, however, that a review of the psychotherapy research (Castonguay & Muran, 2016) and of practice-based evidence supports our central premise: that the heart of effective couple therapy—like the heart of effective psychotherapy in general—consists of the development of a trustworthy therapeutic relationship with the couple. That relationship serves as a secure base and safe harbor in which both partners feel acknowledged and understood, and are thus able to trust and learn to mentalize, and crucially, learn to learn—from the therapist and from each other—even when feeling stressed and threatened. Such openness to learn and to see the other's perspective creates a mental and interpersonal space that allows intimate partners to break the grip that defensiveness and mistrust have fastened on their anguish, their anger, and their loneliness. In so doing, it opens the couple to a "we-mode," a co-mentalizing experience that allows for cooperation, reciprocity, and commitment to shared goals.

SUGGESTIONS FOR FURTHER STUDY

Allen, J. (2021). *Trusting in psychotherapy*. Washington, DC: APPI Press.

Asen, E., & Fonagy, P. (2021). *Mentalization-based treatment with families*. New York: Guilford Press.

Bateman, A., & Fonagy, P. (2016). *Mentalization based treatment for personality disorders: A practical guide*. Oxford, UK: Oxford University Press.

Bateman, A., & Fonagy, P. (2019). *Handbook of mentalizing in mental health practice*. Washington, DC: APPI Press.

Fonagy, P., Campbell, C., Constantinou, M., Higgitt, A., Allison, E., & Luyten, P. (2021). Culture and psychopathology: An attempt at reconsidering the role of social learning. *Development and Psychopathology*. [Epub ahead of print]

REFERENCES

Allen, J. G. (2013). *Mentalizing in the development and treatment of attachment trauma*. London: Karnac Books.

Asen, E., & Fonagy, P. (2012). Mentalization-based therapeutic interventions for families. *Journal of Family Therapy, 34*, 347–370.

Bartels, A., & Zeki, S. (2004). The neural correlates of maternal and romantic love. *NeuroImage, 21,* 1155–1166.

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide.* Oxford, UK: Oxford University Press.

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., . . . Andrews, H. (2012). Maternal postpartum depressive symptoms and 4-month mother–infant interaction. *Psychoanalytic Psychology, 29*, 383–407.

Borelli, J. L., Cohen, C., Pettit, C., Normandin, L., Target, M., Fonagy, P., & Ensink, K. (2019). Maternal and child sexual abuse history: An intergenerational exploration of children's adjustment and maternal trauma-reflective functioning. *Frontiers in Psychology, 10.* [Epub ahead of print]

Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment.* London: Hogarth Press and Institute of Psycho-Analysis.

Castonguay, L., & Muran, C. (2016). *Building partnerships between clinicians and researchers.* New York: Routledge.

Debbané, M., Benmiloud, J., Salaminios, G., Solida-Tozzi, A., Armando, M., Fonagy, P., & Bateman, A. (2016). Mentalization-based treatment in clinical high-risk for psychosis: A rationale and clinical illustration. *Journal of Contemporary Psychotherapy, 46,* 217–225.

Ensink, K., Begin, M., Normandin, L., & Fonagy, P. (2017). Parental reflective functioning as a moderator of child internalizing difficulties in the context of child sexual abuse. *Psychiatry Research, 257,* 361–366.

Feldman, R. (2021). Social behavior as a transdiagnostic marker of resilience. *Annual Review of Clinical Psychology, 17,* 153–180.

Fonagy, P., Lemma, A., Target, M., O'Keeffe, S., Constantinou, M. P., Ventura Wurman, T., . . . Pilling, S. (2019). Dynamic interpersonal therapy for moderate to severe depression: A pilot randomized controlled and feasibility trial. *Psychological Medicine, 50,* 1010–1019.

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psycho-Analysis, 77*(Pt. 2), 217–233.

Gallotti, M., & Frith, C. D. (2013). Social cognition in the we-mode. *Trends in Cognitive Sciences, 17,* 160–165.

Gianino, A. F., & Tronick, E. Z. (1988). The mutual regulation model: The infant's self and interactive regulation and coping and defensive capacities. In T. M. Field, P. M. McCabe, & N. Schneiderman (Eds.), *Stress and coping across development* (pp. 47–68). Hillsdale, NJ: Erlbaum.

Gottman, J. M. (2011). *The science of trust: Emotional attunement for couples.* New York: Norton.

Gottman, J. M. (2021). The *Enhanced Gottman Relational Checkup.* Seattle, WA: The Gottman Institute. https://gottmanconnect.com/checkup/clinicians.

Hausberg, M. C., Schulz, H., Piegler, T., Happach, C. G., Klopper, M., Brutt, A. L., . . . Andreas, S. (2012). Is a self-rated instrument appropriate to assess mentalization in patients with mental disorders?: Development and first validation of the Mentalization Questionnaire (MZQ). *Psychotherapy Research, 22,* 699–709.

Kobak, R., Zajac, K., Abbott, C., Zisk, A., & Bounoua, N. (2017). Atypical dimensions of caregiver–adolescent interaction in an economically disadvantaged sample. *Development and Psychopathology, 29,* 405–416.

Lerner, H. (2017) *Why won't you apologize: Healing everyday hurts and big betrayals.*New York: Gallery Books.

Luyten, P., Campbell, C., Allison, E., & Fonagy, P. (2020). The mentalizing approach to psychopathology: State of the art and future directions. *Annual Review of Clinical Psychology. 16,* 297–325.

Luyten, P., & Fonagy, P. (2015). The neurobiology of mentalizing. *Personality Disorders: Theory, Research, and Treatment, 6,* 366–379.

Luyten, P., Malcorps, S., Fonagy, P., & Ensink, K. (2019). Assessment of mentalizing. In A. Bateman & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (2nd ed., pp. 37–62). Washington, DC: American Psychiatric Publishing.

Midgley, N., Ensink, K., Lindqvist, K., Malberg, N., & Muller, N. (2017). *Mentalization-based treatment for children (MBT-C): A time-limited approach.* Washington, DC: American Psychological Association.

Perel, E. (2006). *Mating in captivity: Reconciling the erotic and the domestic.* New York: Harper.

Phillips, B., Wennberg, P., Konradsson, P., & Franck, J. (2018). Mentalization based-treatment for concurrent borderline personality disorder and substance use disorder: A randomized controlled feasibility study. *European Addiction Research, 24*(1), 1–8.

Robinson, P., Hellier, J., Barrett, B., Barzadaitiene, D., Bateman, A., Bogaardt, A., & Fonagy, P. (2016). The NOURISHED randomized controlled trial comparing mentalisation-based treatment for eating disorders (MBT-ED) with specialist supportive clinical management (SSCM-ED) for patients with eating disorders and symptoms of borderline personality disorder. *Trials, 17*(1), 549.

Rosso, A. M., & Airaldi, C. (2016). Intergenerational transmission of reflective functioning. *Frontiers in Psychology, 7,* Article 1903.

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 51,* 1304–1313.

Sadler, L. S., Slade, A., & Mayes, L. C. (2006). Minding the baby: A mentalization-based parenting program. In J. G. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 271–288). Chichester, UK: Wiley.

Sharp, C., Venta, A., Vanwoerden, S., Schramm, A., Ha, C., Newlin, E., . . . Fonagy, P. (2016). First empirical evaluation of the link between attachment, social cognition and borderline features in adolescents. *Comprehensive Psychiatry, 64,* 4–11.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development, 7*(3), 269–281.

Troyer, D., & Greitmeyer, T. (2018). The impact of attachment regulation strategies on empathy in adults: Considering the mediating role of emotion regulation strategies andd negative affectivity. *Personality and Individual Differences, 122*, 198–205.

Tuomela, R. (2005). We-intentions revisited. *Philosophical Studies, 125*(3), 327–369.

Winnicott. D. W. (1971). *Playing and reality*. New York: Penguin.

Zeegers, M., Colonessi, C., Stams, G., & Meins, E. (2017). Mind matters: A meta-analysis on parental mentalization and sensitivity as predictors of infant–parent attachment. *Psychological Bulletin, 143*(12), 1245–1272.

CHAPTER 9

Intergenerational Factors in Couple Therapy

Mona DeKoven Fishbane

BACKGROUND

The approach to couple therapy described in this chapter highlights intergenerational factors impacting couple distress and techniques to transform couple impasses. Therapies with a focus on family of origin have influenced clinical practice since the beginning of modern couple therapy. This chapter reviews contributions from intergenerational theories, offering an approach that integrates these ideas with the vulnerability cycle (Scheinkman & Fishbane, 2004), informed as well by research on couple relationships and interpersonal neurobiology.

The Past Matters

"The past is never dead; it isn't even past" (Faulkner, 1975). Attachment dynamics from childhood are lived out in couple relationships. Experience, particularly early in life, shapes connections between neurons in the human brain (Siegel, 2015). The amygdala (the part of the brain that sets off the fight-or-flight response when one senses threat) is particularly affected by early experience; it also stores and processes emotional components of memories. Unfinished business and old memories from the family of origin intensify couple reactivity, as childhood wounds are reactivated. Linking current couple impasses to unresolved family issues contextualizes and deepens the understanding of couple interactions—and is often transformative for both partners.

Experience not only shapes neuronal circuits; it also affects the expression of genes, or epigenetics (Meaney, 2010). The nature versus nurture debate has been put to rest by neuroscientists; nature (genetics) and nurture (experience, especially early in life) mutually affect each other. Remarkably, it appears that some of these epigenetic changes are passed on intergenerationally (Champagne, 2008). Intergenerational transmission of trauma is likely shaped by epigenetics as well as lived experience in the family (Yehuda & Lehrner, 2018).

There is a fine line between tracing old wounds to the family of origin and blaming parents for clients' problems—a not uncommon phenomenon in therapy. Within the family field, "the schizophrenogenic mother" and "refrigerator parents" of children with autism are among the most egregious examples. Ivan Boszormenyi-Nagy, whose "contextual therapy" approach anchors this chapter, contends that such parent blaming in therapy has deleterious effects on clients. Therapists needn't pit themselves against parents or pit clients against parents in order to acknowledge the role of the past in clients' current functioning. The contextual therapist extends concern to parents as well as the adult child client, holding a compassionate rather than a blaming stance toward the family of origin. Interventions are geared to help clients "grow up" their views of parents and siblings, toward a more complex and compassionate perspective.

In addition to exploring the role of the past and intergenerational family dynamics in couple reactivity, the therapist encourages clients to consider new perspectives and repair within current family-of-origin relationships. There is often a positive synergy between healing old family wounds and improving the couple relationship.

Key Contributors to Intergenerational Family Therapy: Founders and Expanders

Intergenerational family therapists were among the founders of family therapy, including Murray Bowen, Ivan Boszormenyi-Nagy, and James Framo. Bowen's theory of differentiation was a major contribution to the field. Framo (1981) was one of the earliest pioneers of family-of-origin work in couple therapy. Getting to know parents as real people on their own life journey, a central theme in this chapter, develops out of Framo's work. The contextual therapy of Boszormenyi-Nagy and colleagues, and its perspective on relational ethics, is a centerpiece of the approach presented here. Contextual therapy focuses on healing wounds from the past, repairing problematic intergenerational relationships in the present, and cultivating legacies for the future.

Bowen (1978) posited that anxiety leads to fusion or cutoffs within the family of origin, affecting subsequent adult relationships. His approach emphasizes autonomy and differentiation, being able to hold one's own ground and not be excessively influenced by the needs and opinions of others. Bowen theory addresses the forces of autonomy versus togetherness, and the struggles to find a balance between them. His emphasis on autonomy and pathologizing of fusion has been criticized for being culturally myopic; many cultures value greater connectedness than Bowen endorsed. Bowen also identified tensions between reason and emotion, encouraging greater rational control. Feminists have critiqued this perspective, pointing to a male bias toward reason over emotion. From a neuroscience perspective, both reason and emotion are important; it is their integration that allows for healthy functioning (Siegel, 2015).

Bowen developed the concept of triangles; he posited that when there is anxiety in the family, it passes from one member to another. Tension between two people, according to this theory, is often managed by "triangling in" a third party: a child (who may become symptomatic), an affair, use of substances, and so forth. Boundaries are important in Bowen theory: ideally clear and strong, but flexible, and culture-dependent in their form and function.

Differentiation is one of the enduring legacies of Bowen therapy, and has been adopted by many couple therapy approaches. For Bowen, differentiation focuses on maintaining one's own position and not getting drawn into family anxiety or dramas. Bowen's ideas about differentiation have been expanded and updated. A more relational view of differentiation is developed in this chapter.

Intergenerational therapists, influenced by Bowen practice, routinely use genograms in their work: drawing a family tree for each client, identifying losses and patterns of closeness–distance, mental illness, divorce, substance abuse, and so forth, going back multiple generations (McGoldrick, 2016). The use of the genogram, which has become quite common among therapists more broadly, facilitates a systemic and intergenerational perspective in clients.

James Framo was one of the first couple therapists to include family-of-origin sessions in his treatment. He encouraged adult clients to get to know their parents as real people; according to Framo, this process can replace outdated parental introjects from childhood with more accurate, sympathetic views of parents. Framo supported clients becoming compassionate and forgiving rather than heightening anger at parents.

Ivan Boszormenyi-Nagy ("Nagy") and colleagues developed "contextual therapy," an intergenerational approach that highlights family obligations, loyalties, and legacies. It is rare among therapists to focus on what adults owe their parents. Nagy contends that adults owe their parents a debt of "filial loyalty"—the loyalty of a child toward parents—for the care given them in childhood, even if that care wasn't optimal. He claims that if adults are stuck in resentment or cutoff with their parents, and don't repay the filial debt, they are likely to live out unhealthy patterns from their family of origin in their current relationships, through a process of "invisible loyalties" (Boszormenyi-Nagy & Spark, 1973). They may seek to collect damages for the wounds of their childhood, but at the wrong address—looking to their partner or child to make up for what they didn't receive early in life. Thus, Nagy claims, "the victim becomes the victimizer" through "the revolving slate of vindictive behavior" (Boszormenyi-Nagy & Ulrich, 1981, p. 167).

Nagy's contextual therapy focuses on "relational ethics," the balance of give-and-take in family and other relationships (Boszormenyi-Nagy & Krasner, 1986). In this regard, Nagy was influenced by Martin Buber and his philosophy of dialogue. Both Nagy and Buber emphasized the obligations people have to the others with whom they interact. This emphasis on relational ethics and obligations sounds foreign to many couple therapists but is central to contextual therapy.

Building on the work of these founders, subsequent generations of family theorists have expanded intergenerational clinical work, considering larger sociocultural contexts in which families are embedded, with a focus on diversity, injustice, and trauma (McDowell, Knudson-Martin, & Bermudez, 2018; McGoldrick & Hardy, 2019). Harriet Lerner (1985) brought Bowen theory to the general public, refining the approach. Evan Imber-Black developed theory and interventions around family rituals and secrets (Imber-Black, 1993; Imber-Black, Roberts, & Whiting, 2003). Froma Walsh has made major contributions to our understanding of loss (Walsh & McGoldrick, 2004) and spiritual resources (Walsh, 2010) in the intergenerational family. Walsh's (2006) work on family resilience resonates with contextual therapy. The therapist, while addressing problematic intergenerational family dynamics, also helps clients identify sources of resilience or "resources of trustworthiness" (Boszormenyi-Nagy & Krasner, 1986) in the family of origin. Hargrave and Pfitzer (2003) have further developed contextual theory and relational ethics in couple and family therapy. Finally, while not referencing contextual therapy, recent work explores "narrative ethics" in couples, the relational-ethical impact of one person's behavior on the other (Carlson & Haire, 2014).

Interpersonal Neurobiology

Research from interpersonal neurobiology sheds light on couple and intergenerational dynamics. Of special interest are the neurobiology of emotional memories, behavioral patterns, and traumas from childhood that impact couples in their current interactions; intergenerational transmission of stress and trauma; and research around emotion dysregulation, emotion regulation, and empathy. Understanding the neurobiology of habits and change sharpens an appreciation of the power of habits formed in childhood, informing processes of change in couple therapy.

Culture, Identity, and Power: The Relational Self

As noted earlier, more recent intergenerational theorists attend to larger sociocultural contexts. Experiences of discrimination such as racism, sexism, or homophobia, or of trauma from war, immigration, or poverty, shape partners' vulnerabilities and survival strategies (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). Some of these impacts go back generations in the family of origin; traumas that affected ancestors may still haunt their descendants, shaping partners' sensitivities in the couple relationship. On the other hand, sociocultural resources such as a faith community or other sources of social support can sustain couples and families, strengthening their resilience. The couple therapist informed by intergenerational theory is sensitive to the cultural background and values of clients, assessing intergenerational-cultural wounds, as well as strengths that impact couple functioning.

The dominant U.S. culture privileges "Power Over" (a win–lose competitive model of relationships) and individualism, valuing individual rights over responsibility to others. By contrast, many collectivist cultures emphasize responsibility and concern for other as well as self, and obligations within the intergenerational family. Couple therapy is enhanced by incorporating a nuanced view of power, addressing Power Over imbalances between partners, while offering clients techniques for developing "Power To" (living according to one's higher values) and "Power With" (co-creating a relationship of respect, fairness, care, and compassion; Fishbane, 2011).

The relational–intergenerational approach presented here challenges assumptions and values of the culture of individualism and competition that negatively impact couples; it is influenced by contextual theory, relational–cultural therapy (Jordan, 2010), the dialogical philosophy of Martin Buber, and research from psychology and interpersonal neurobiology. These various schools of therapy and bodies of research point to a relational view of the human being. Identity is not something one authors alone; it emerges in relational contexts. Within couples, partners enhance or diminish each other's identity (Carlson & Haire, 2014).

Legacies: An Eye to the Future

Intergenerational therapy addresses legacies inherited from prior generations (consciously or unconsciously) and legacies passed on to the future (intentionally or unintentionally). How one relates to the past affects how one acts in the present and what is bequeathed to the future: "The dimension of relational ethics can be thought of as a bridge from one's past, stretching through oneself to the future" (Hargrave & Pfitzer, 2003, p. 21). The therapist helps clients reflect on and become more intentional about their family legacies and beliefs. This can be transformative for couples who are living out unfinished business from the past, enhancing choice rather than automatic reactivity in the couple relationship.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

The language clinicians use affects interaction with clients. It is more productive to describe unhappy couples as "distressed" rather than "dysfunctional." The latter term is judgmental, setting therapist against the client. Furthermore, behaviors that are causing distress within the couple—often based in survival strategies—while problematic now, may have been adaptive in the family of origin. For example, a child emotionally overwhelmed in a volatile family survived by shutting down and shutting out other people. But now, when the survival strategy of stonewalling is used with the partner, it contributes to relationship misery. The therapist explores the survival value in the past of partners' defensive behavior. Problematic survival strategies do need to be challenged in couple therapy—but from a place of respect and compassion for the contexts in which they evolved.

Falling in Love, Long-Term Love

Researchers have identified the trajectory of love in couple relationships, from the heady "falling in love" stage, compared by neuroscientists to being high on cocaine (Fisher, 2004) to the fading of romantic passion and perhaps some disillusionment as the rose-colored glasses of early love yield to a more realistic view of the partner. Researchers have tracked the transition from romantic to companionate love; both kinds of love diminish over time in couple relationships (Hatfield, Pillemer, O'Brien, Sprecher, & Le, 2008). For long-term love to thrive, it needs to be nurtured proactively.

Happy couples cultivate the "we," respect each other, repair well and often, and nurture positivity (Gottman, 2011). Long-term love takes work, commitment, compassion, and generosity of spirit. But this is easier said than done. The pain and disillusionment when the rose-colored glasses come off are often exacerbated by seeing the partner through the filter of unfinished business from one's family of origin. Consider this couple, married 10 years: Whereas early in their relationship Amanda had eyes only for Susan, now Amanda is distracted by her work and often unavailable. Susan, feeling abandoned, gets triggered as she relives the abandonment she felt with her busy parents. Susan becomes critical. Amanda feels attacked, much as she felt with her parents. This couple's vulnerability cycle is fueled by old feelings. For the couple to withstand the disappointment of infatuation's passing and work together to build a more lasting love, they need to reckon with wounds from the past that are reactivated with each other.

The Vulnerability Cycle: A Cycle of Hurt and Blame

As partners trigger each other, they often get polarized in their dance (the more unavailable Amanda is, the more critical Susan becomes; the more Susan criticizes, the more Amanda withdraws). Vulnerabilities from childhood are activated (e.g., a sense of inadequacy, feeling unprotected, overwhelmed, or abandoned), triggering self-protective survival strategies (e.g., defending, withdrawing, criticizing, or attacking). The survival strategies of one trigger the vulnerabilities of the other, activating in turn the other's survival strategies, as the couple gets caught in an escalating cycle of reactivity (Scheinkman & Fishbane, 2004).

Distressed couples see their interaction in linear terms, each feeling like a victim and blaming the other. Happier couples, while they may get upset with each other, are able to "get meta" (Fishbane, 2013), looking at their cycle from above; they see their interactions as circular, taking responsibility for their own contribution to the cycle.

When partners are able to speak directly from vulnerability ("I've been missing you, Amanda") rather than attack from survival strategy ("You're so selfish! All you care about is your work!"), they are more likely to get a sympathetic response. Speaking from vulnerability elicits empathy; attacking from survival strategy begets defensiveness, counterattack, or withdrawal (see also Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe,

& Allan). Partners with flexible and adaptive survival strategies are more likely to be successful in relationships. If survival strategies haven't evolved since childhood, they may be rigid and inflexible. As a child, Amanda learned the technique of storming into her room and slamming the door, shutting out her critical parents. She uses this version of self-protection with Susan with damaging results. In therapy, Amanda works to "grow up" her survival strategies, so they are more adaptive: negotiating a time-out or confiding in Susan how hurtful the criticism is. Reciprocally, Susan learns to put forth her needs and concerns in a more inviting manner.

Repair

Happy couples repair well and often (Gottman, 2011). Repair is a complex process, including awareness of the other's hurt and perhaps feeling guilt over one's role in the hurt. Many people are allergic to guilt. Martin Buber (1957) differentiated between healthy and neurotic guilt. While neurotic guilt is damaging and pervasive, healthy guilt is one's conscience, an acknowledgment of having hurt another, prompting repair. Repair also entails apology. If one was forced or humiliated into apologizing as a child, it may be hard to apologize to the partner now. Finally, repair entails forgiveness. Some people refuse to forgive, fearing that if they do, they will lose their leverage or be taken advantage of in the future. The experiences and role models each partner had in the family of origin for apology and forgiveness can help or hinder the partners now in their attempts at repair.

Intergenerational Factors in Couple Distress

Secure attachment with parents in childhood promotes trust and a sense that relationships are benevolent and safe. This sense of trust is brought to the adult intimate relationship, as the couple develops a secure bond. But if one or both partners did not experience secure attachment in childhood, it may be harder to trust each other. Attachment wounds from childhood haunt the couple now. Hurtful couple interactions confirm that others are not to be trusted, and a cycle of distrust develops. A blaming, resentful stance from childhood may be reenacted with the partner. Feeling like a victim of parents often leads to a more generalized victim stance, including in the couple relationship.

Each partner's vulnerabilities and survival strategies, which fuel the couple's cycle or impasse, stem from experiences earlier in life, particularly in the family of origin. As explored below, linking these internal processes of hurt and self-protection to experiences in childhood can soften the couple interaction, facilitating partners' increased capacity for self-responsibility and compassion.

Interpersonal Neurobiology and Couple Distress

Humans function on autopilot most of the time, driven by emotions and habits wired into the brain since childhood. Happier couples are more thoughtful and able to choose their responses, and less driven by old habits or emotional reactivity. Research links emotion regulation with couple satisfaction (Bloch, Haase, & Levenson, 2014). The therapist helps distressed couples develop skills of emotion regulation, increasing proactive choice rather than knee-jerk reactivity.

Unhappy couples get caught up in negativity (see also Chapter 16, in this volume, by Gottman & Gottman), becoming emotionally dysregulated, driven to fight-or-flight by their amygdala. Instead of offering comfort, partners become sources of threat to each other. Rather than "you have my back" (a position of secure attachment), they feel, "I have to watch my back with you." Even in the absence of physical violence, or when the threat is as small as a raised eyebrow, partners can become reactive. The nature of the threat is frequently related to experiences in childhood. Thus, a critical partner evokes emotional memories of a critical parent. And emotions are contagious; when Susan's reactivity amps up, as she feels abandoned, Amanda also feels threat; both become emotionally dysregulated, although they express their distress differently (Susan with angry criticism, Amanda with angry withdrawal). Both see red; neither is able to think straight. When the amygdala takes over, the higher brain, the prefrontal cortex, goes offline. The therapist helps distressed couples develop tools for emotion regulation and explore issues from the family of origin that are activated in the couple escalation. In identifying their survival strategies and reflecting on the intergenerational contexts in which they evolved, clients increase thoughtfulness and decrease knee-jerk reactivity.

Power

A competitive, Power Over approach to conflict characterizes many unhappy couples. Clients who grew up feeling disrespected or disempowered may be more inclined to utilize Power Over behaviors with their partner. Happier couples are able to share power, rejoicing in each other's successes, offering compassion in the face of hurt, making room for each other's voice.

Narrative Ethics

The stories one tells, and the capacity to tolerate different perspectives, have relational and ethical implications. Distressed couples often struggle over reality, arguing for an entire session over what happened last Thursday. Underneath the fight lurks the question of whose fault it was. Happier couples make room for both their realities. Each one cares about how the other sees the world and their relationship. If partners were raised in families where there wasn't room for their own experience, they may be more inclined to fight over reality with their partner.

The therapist helps clients consider the stories they tell about their partner and family of origin. The lenses through which adults see their parents are often the same lenses through which they see the partner. The capacity to rethink one's narratives and make room for multiple perspectives differentiates happy from distressed couples.

THE PRACTICE OF COUPLE THERAPY

The Structure of the Therapy Process

Who Is the Client?

Therapists disagree about this question. Is the relationship itself the client? Or each individual partner? With a viewpoint informed by Nagy's concept of multidirected partiality, the answer is both–and. The therapist sides with each individual, while also holding concern for the relationship itself.

Gina and Larry have been married for 15 years and have two young children. Larry feels stifled and wants to separate; Gina is desperate to save the marriage. The stakes are high, given the young children. It is clear that Larry is no longer willing to stay in an unhappy marriage. The therapist says,

> "The old relationship isn't working. You, Larry, want out. But you, Gina, really want to stay married. What if we say that the old marriage is no longer viable, it just doesn't work? It's not fair to ask Larry to stuff himself back into an unhappy relationship. Given that you have a long history together and two young children, let me make a proposal and see if it works for both of you. Might we meet for 3–6 months and see if you can create a new relationship, one in which both of you can flourish? If so, great. If not, you can separate in a way that is respectful and less damaging to your children."

Most couples are open to such a proposal. This work is not called "marital therapy," since that implies a bias toward "saving the marriage." It is "couple therapy": a space for two individuals to see if they can co-create a more satisfying relationship.

Larry and Gina embark on this time-limited project. The therapist helps each explore family-of-origin experiences relevant to their relational impasse. Larry shares that his parents stayed together in a miserable marriage; his father confided to Larry that he was afraid to start again on his own. Larry determined that he would never become trapped like his father in an unhappy relationship. Such "corrective scripts" can be as constraining as "replicative scripts" (Byng-Hall, 2004), when one either repeats the same patterns as the family of origin or goes in the opposite direction. Gina's parents divorced when she was young; her mother became embittered and barely functional. Gina determined that her children would never know the anguish of divorce. Both partners were shaped by their family-of-origin wounds. The therapist helps Larry and Gina create a new script for their relationship that isn't haunted by the past.

Children are not usually included in couple sessions. Nevertheless, with a contextual perspective, the therapist is concerned about the impact of the couple's relationship on the children and about the impact on the couple relationship of children who are particularly challenging. If indicated, family sessions with the couple and their children can be held.

Individual and Couple Sessions

Couple therapy is enhanced when each partner is or has been in individual therapy that increases reflectiveness and self-responsibility. (The exception is if the individual therapist sees their client as victim and blames the partner, without encouraging the client to explore their own issues.) In couples where partners have not been in individual therapy, the therapist may refer one or both to an individual therapist to do parallel work to the couple therapy; or the couple therapist may periodically see both partners individually, in addition to couple sessions. In individual sessions, clients are encouraged to consider their own survival strategies in the context of their families growing up. Reflecting on how and when one uses these survival strategies in the couple relationship facilitates differentiation, self-responsibility, and relational empowerment.

An agreement is created about confidentiality around individual disclosures in these sessions. Couple therapy is not viable if one partner asks the therapist to keep a secret (e.g., an affair). The ground rules for individual meetings make it clear that while it is not the therapist's place to convey private information between partners, if there are secrets, couple therapy cannot continue. Trust in the therapeutic relationship is key, and secrets betray that trust.

The Role of the Therapist

Multidirected Partiality

Couples often come to therapy blaming each other for their unhappiness, looking to the therapist as judge. A balanced therapeutic alliance is crucial for the success of couple therapy; the therapist does not accept the role of judge. If there is egregious or abusive behavior, the therapist takes a stand; violence is out of bounds and the principle of safety first is bedrock in any therapy. Nevertheless, even setting limits and identifying problematic behavior is done from a place of concern and compassion. The therapist maintains a stance of "multidirected partiality" (Boszormenyi-Nagy & Krasner, 1986): partial to each partner, on each one's side. When clients feel understood and affirmed, the therapist can challenge them. Multidirected partiality is not neutrality; the therapist cares about both partners, is partial to each. But the partiality is balanced.

Clients come to therapy discouraged and disempowered, bringing their failures and sense of inadequacy. This is especially the case in couple therapy, as partners highlight each other's flaws and problems. The potential to feel shame is high. The couple therapy office must be a "shame-free, blame-free zone" (Fishbane, 2013), a safe environment for clients to explore their vulnerabilities and relational disappointments.

It is the therapist's job to "get" each partner empathically, both in their current functioning and their history. This is partially a cognitive process. But it is much more than that. Therapeutic presence—emotional, physical, cognitive—is crucial; each partner must "feel felt" by the therapist (Siegel & Hartzell, 2003).

Despite aiming for a balanced alliance, therapists may prefer or identify with one partner over the other. Therapists can get triggered with clients. It is crucial that clinicians be aware of their own vulnerabilities and survival strategies, and note when they get caught up in a vulnerability cycle with clients. Therapists need to address unfinished business with their own family of origin. Bowen trainees spend considerable time on this work, but all therapists need to work through their own issues and be alert to the potential for countertransference. This is particularly important for couple therapists, who may be pulled into a triangle, siding with one partner over another.

Compassion, Respect, and Curiosity

The therapist holds a stance of compassion, helping clients give voice to their vulnerabilities, yearnings, and pain. Each must feel understood and validated, that their vulnerabilities are held with care, their survival strategies respected. It may be difficult for the therapist to show this respect to a partner who is being harsh, defensive, or shutting down. But once the therapist hears the family-of-origin context in which vulnerabilities and survival strategies evolved, it is easier to convey that respect. It is only from this position of affirmation that problematic aspects of survival strategies can be challenged. Validating one partner may lead to the other feeling disregarded or criticized; the therapist must constantly balance validating and holding both partners, even while challenging them.

The therapist cultivates curiosity. We have our hunches and theories. But we need to "hold our theories lightly," remembering Bateson's (1988) adage "the map is not the territory." In a perspective informed by Buber's philosophy, "the therapist must be ready to be surprised" (Friedman, 1965, p. 37). With this stance, clients are less likely to feel objectified; they are co-creators of the therapeutic process.

"Resistance" and Client Feedback: A Collaborative Approach

Therapy doesn't always proceed smoothly; clients "resist" clinical interventions. This approach is collaborative, viewing "resistance" as important feedback. It is vital that the therapist not engage in a power struggle with clients; hence, "resistance" is in quotation marks here. If clients complain that the therapist is imbalanced or judgmental, the therapist takes that in, thanking them for the feedback. A client may push back when the therapist steps on a survival strategy, advocates too strongly for change, or challenges ties to the family of origin. Nagy points to the danger of therapists pitting themselves against parents, putting the client in a loyalty bind. "Resistance" is often the result.

While collaborative, this is not a *laissez-faire* approach. The intergenerationally oriented couple therapist is active, wearing different hats at different times: witness, coach, teacher, explorer of past influences on current impasses, facilitator of emotional expression and dialogue. At times the therapist is quiet, letting the couple enact their dance; at other times, more interventionist. If partners' emotions get escalated, the therapist encourages them to take a breath, pause, and reflect on what just happened.

A Nonblaming Approach: Extending Multidirected Partiality to the Intergenerational Family

Informed by contextual theory, the therapist holds in mind every person affected by this therapy, not just the individual or couple who comes in for treatment. How are children affected by what the couple does in therapy? How are parents or siblings affected by a treatment that may not include them directly? Nagy goes so far as to think about the consequences of this therapy on unborn future generations!

Therapists who blame parents for a client's problems create "iatrogenic" problems for the client (Boszormenyi-Nagy & Krasner, 1986). Sara comes to therapy because she struggles in intimate relationships. She feels unworthy, a sense she's had since childhood. Sara's prior therapist challenged this self-blame, placing the blame squarely on the shoulders of her critical parents. As a result of that therapy, Sara became resentful toward her parents. She came in with one problem—low self-esteem—and ended up with another—parental alienation. Parent-blaming by the therapist sets up a loyalty bind for the client between the "good" therapist and "bad" parents (Boszormenyi-Nagy & Ulrich, 1981). This is a particular pitfall for many therapists who were rescuers in their own family of origin, now dedicated to rescuing clients from "bad" parents, perhaps even recommending that the client cut off or distance from parents. While on rare occasions a parent may be currently dangerous (e.g., violent or abusing substances), most parents are not evil, violent, or psychotic; they are simply functioning with their own vulnerabilities and survival strategies. Pitting client against parents is damaging, likely to keep the client stuck in a victim position—lived out now in the couple relationship. When Sara feels upset with her boyfriend, she blames him—the only alternative she has to blaming herself. The blame stance is pervasive in her life.

Contextual therapists endorse a more expansive and compassionate view of parents in their own intergenerational context, extending multidirected partiality to the family of origin. This is a systemic view, honoring clients' frustrations with parents, as well as their attachment to them, and considering the parents' perspective at the same time. The therapist is not challenging the client's story of childhood pain, or denying or whitewashing the wounds of the past. Rather, the client is helped to understand parents' limitations in terms of their life journey. Working with a different therapist with an intergenerational orientation, Sara now explores her parents' critical behavior—which contributed to her feeling unworthy—in light of legacies of criticism that extend back many generations in her family of origin.

Assessment and Treatment Planning

Formal questionnaires or screening tools are not utilized, but individual and relational strengths and challenges are assessed, considering individual, interpersonal, intergenerational, neurobiological, and sociocultural levels of functioning.

Why Now?

Like most other couple therapists, my first question is why is this couple calling now? What has changed in their lives that is prompting them to seek treatment? Who makes the call? Do both partners want to come to therapy? What are their agendas (which may differ)? Does one want to leave the relationship, while the other wants to work on it? Did a crisis prompt the call for treatment? Partners may not be equally motivated to work on their relationship or stay together. Assessing motivations and goals is crucial.

Safety and Power

Assessing for safety is always a central concern. Is there a risk or history of violence, drug or alcohol abuse? Does one feel threatened, or unsafe, even without physical abuse? What are the couple's power dynamics? Does one partner regularly defer and the other prevail? What options does each have outside the relationship? If one partner is dependent on the other financially, with no resources of their own, power may be limited. Rather than assuming that partners are equal, the therapist assesses power differentials, including those related to race, class, or education. In mixed-gender couples, power issues related to gender have particular import.

Couple Interaction

From the beginning, the therapist assesses couple interaction. The first phone call often reveals the basic couple dance (e.g., pursue–distance or criticize–defend). As therapy progresses, the interactional patterns emerge more fully, and couple and therapist co-construct the vulnerability cycle diagram (see the diagram below in the case example). The therapist assesses the flexibility or rigidity of each partner's survival strategies, identifying the vulnerabilities underneath. Over time, the intergenerational backstory of each partner's vulnerabilities and survival strategies emerges. Family history is discussed, including attachment histories, losses, or abuse.

Individual Functioning

The therapist evaluates the emotional stability and functioning of each partner. Is there depression, anxiety, or other mental illness? If so, is it being treated? Does either have physical or health challenges? How able are they to tolerate frustration, criticism, or emotional intensity? What are their emotion regulation skills? What is their capacity for mentalization and dialogue (Fishbane, 1998; Fonagy, Gergely, Jurist, & Target, 2005)? Can they make room for each other's perspective? How generous is each partner with the other? Or are they more competitive?

Larger Contextual Stressors and Resources

The therapist assesses the couple's sociocultural resources and stressors. If they have children, are there emotional, cognitive, or health issues? What are the stressors or strains for the couple vis-à-vis their families of origin? Have they experienced trauma or oppression such as racism, marginalization, or homophobia? The assessment may extend further back, to trauma in preceding generations, as in Holocaust survivor families, descendants of slaves, or war or immigration experiences. What are the intergenerational legacies of pain or humiliation, trauma or loss, that may be impacting these partners now? In addition to considering stressors in the larger familial and cultural context, the therapist evaluates strengths and resources. What support is available to this couple from families or friends? Are there faith resources or other communal connections that sustain them?

Developmental Journeys

The therapist considers clients' developmental journeys as individuals and as a couple. What prior relationships has each had? How did they get together? Did they fall in love? How has their relationship evolved? When did their problems start? The couple's work and financial status are assessed as well. Job insecurity and poverty are highly stressful for couples.

Family of Origin

Tracking intergenerational family dynamics is inherent in this approach from the beginning. As the couple tells their story, the therapist begins drawing their genograms. This isn't a formal project in the first session; the therapist meets them where they are, hearing the story of their current pain. But as they make references to "when your mother showed up out of the blue without calling" or "when your brother left the family business," they are asked to identify who's who in each family of origin. At some point during the first few sessions, therapist and couple fill in the genograms, identifying family members and exploring the quality of the relationships and experiences of loss, abuse, or other violations in the multigenerational family.

Relational Ethics

Throughout therapy, and starting with the first phone call, the therapist attunes to the interplay of relational ethics in the couple, a key concern of Nagy's contextual approach. What are the levels of trust and trustworthiness in each partner? Do they experience their relationship as fair? Are they able to hold each other in mind and tolerate multiple viewpoints? Does each have a voice, and can they hear the other? The ability to consider the impact of their behavior on the other's well-being is explored. Of particular import is each partner's capacity for taking responsibility and listening with respect and curiosity. The therapist assesses the extent of blame in their interactions, the ways they have disappointed and hurt each other, and their ability for empathy and repair.

Goal Setting

Treatment goals are unique for each couple, although most would say they want to be happier and have better communication. The identification of more specific goals is a collaborative process between therapist and couple. Initially, each partner may have different goals (e.g., “I want her to get off my back and give me space”; “I want him to be more available at home”). Yet, fundamentally, most partners want similar things. As homework, I ask each to write “The Ten Commandments of Our Relationship.” The lists often include being cherished, respected, and treated with kindness; having fun and increasing intimacy; and trusting each other. From these lists, their joint values and goals are identified and operationalized, targeting behaviors that reflect these goals. Occasionally, partners have very different values that cannot be mutually accommodated. Therapy can be used productively to identify irreconcilable differences and, if the couple chooses, to separate with the least possible damage (see Chapter 21 on divorce, in this volume, by Lebow).

Therapists bring their own goals to couple therapy, shaped by their theoretical orientation. For a clinician informed by intergenerational and particularly by contextual theory, a core goal is facilitating mutual responsibility and relational ethics. Distressed couples often feel disconnected, each partner disconfirming the other. One of the goals of therapy is to develop a shared narrative that incorporates a “we,” as well as each “I,” rekindling the connection and affirmation they had early on. For many couples, the crazy-in-love time was the high-water mark of their relationship, when they had eyes only for each other. The loss of affirmation and passion is painful as partners take each other for granted. Instead of gazing at each other, they focus on work or kids; instead of socializing together, they seek connection through social media on their devices. There are relational-ethical implications of these practices that are damaging to couples.

As noted, values from the culture of individualism and competition can be damaging to couples. The therapist helps partners consider their responsibility to each other, as well as their rights. They are encouraged to become more empowered, live up to their higher values, and “reach for their best self.” Carrying old wounds and resentments from the family of origin can impair the ability to be one’s best self with the partner; “growing up” one’s survival strategies is enhanced by “growing up” views of and relationships with family of origin.

Termination

Termination is not an extended process. Therapist and clients jointly assess regularly how the couple is progressing toward their goals. When they have largely met their goals, or want to practice more on their own, they may stop, take a break, or have longer spacing between sessions, using monthly or bimonthly meetings as “checkups.” Should something come up that needs therapeutic attention, they can always call. Treatment is not “terminated”; the therapist is available in the future should the need arise. Couples are encouraged to call if needed, without waiting for a crisis. Reengaging in couple therapy is not a sign of failure. The therapist is a long-term resource for the couple. Even if they don’t come back to therapy, many couples hold the work and the therapist in mind, enhancing their ability to “get meta” without necessarily returning to therapy.

The Process and Technical Aspects of Therapy

I now explore interventions to help the couple work through their impasse, starting with the vulnerability cycle, with interventions to increase relational empowerment and generosity. The focus is then deepened to explore intergenerational wounds, as well as current relationships with families of origin. Healing old wounds and developing new perspectives on intergenerational relationships can free the couple to coauthor their relationship in keeping with their values.

Transforming the Vulnerability Cycle

THE FIVE “DISSES”: FROM BLAME TO EMPATHY AND SELF-RESPONSIBILITY

After many repetitions of their cycle, distressed couples often experience the five “disses”: Partners are discouraged, disconnected, dysregulated, disempowered, and “dissing” each other. Each is helpless as the familiar cycle unfolds. The therapist facilitates the development of hope and agency through increasing connection, learning techniques for emotion regulation, building skills of relational empowerment, and enhancing respect—antidotes to the “five disses.” Whereas “dissing” or blaming—holding a linear view with self as victim and partner as the problem—reflects a lack of self-responsibility and agency, the therapist offers a circular view of their interaction, working toward mutual empowerment and responsibility. The shift from blame and self-protection to empathy and self-responsibility engenders a proactive rather than reactive stance in each partner.

FROM AUTOPILOT TO CHOICE

Couples caught up in reactivity are driven by their emotional brains. Living on autopilot, they enact habitual, unproductive sequences based in survival strategies developed in the family of origin. The therapist helps each partner bring prefrontal thoughtfulness to amygdala reactivity. The ability to choose their response rather than react habitually is empowering for clients.

Partners work to become authors of their own responses and coauthors of their relationship rather than victims of each other. They consider the impact of their behavior on the other's sense of self, cultivating "preferred relationship practices"—lived aspects of relational ethics (Carlson & Haire, 2014). This shift to thoughtful authorship in their responses to each other is enhanced as partners explore family-of-origin factors that have fueled their own reactivity.

EMOTION REGULATION

Emotion regulation is key to transforming the vulnerability cycle. There are individual differences in the capacity to self-regulate, due to both genetic variation in stress reactivity and childhood experiences (McLaughlin, 2017; Rodrigues, Saslow, Garcia, Joh, & Keltner, 2009). Techniques for emotion regulation have been well researched by psychologists and neuroscientists. They include "top-down" cognitive techniques, such as naming one's emotion (which activates the prefrontal cortex and calms the amygdala) and reappraisal (reframing), a mental shift that allows one to see the partner in more open or sympathetic ways. Identifying goals, values, and intentions can also help clients moderate their reactions. Other emotion regulation strategies are more body-based, "bottom-up" techniques such as deep belly breathing, mindfulness meditation, or taking a break to calm down (Gottman, 2011).

CONSTRUAL HUMILITY

Humans are meaning-making creatures, and the right to narrate one's own life is held dear. Partners in a couple, seeing the same moment in different ways, may engage in "dueling realities" (Anderson, 1997). Making room for multiple narratives and differences of perspective and opinion, and recognizing the right of each to their own experience, are key aspects of relational ethics. Mentalization (Fonagy et al., 2005) is the awareness that others have their own ways of thinking and experiencing. Yet in some couples, a partner, assuming that there's only one way to see things—their own way—may try to force their view of reality on the other. The therapist offers "construal humility" as a model, noting that we all construe or make sense of our world, but there are multiple ways to look at most interactions. Making room for dual narratives rather than dueling narratives is a key skill of relational ethics in both couple and intergenerational relationships.

DRAWING THE VULNERABILITY CYCLE DIAGRAM

The couple's dance is usually apparent from the first session. The nuances of each partner's survival strategies and the vulnerabilities fueling them are not so readily apparent, but emerge over the course of several sessions, at which point couple and therapist together draw the diagram (Scheinkman & Fishbane, 2004). Couples appreciate seeing their personal and interpersonal dynamics in the diagram, understanding how each one's self-defense is triggering the other. The circular nature of the interaction becomes clear.

As they draw their vulnerability cycle diagram, the couple is exploring their interactional patterns as a team, with a "joint platform" (Wile, 2002). Some couples put their diagram on their refrigerator, saying, "This is the dance we do together." They are externalizing the cycle (Scheinkman & Fishbane, 2004), examining their dynamics with less blame and more coresponsibility, and cultivating the "We" (Gottman, 2011).

The identification of vulnerabilities and survival strategies must be done with respect and care, without shaming clients. Even though survival strategies may be problematic, the therapist, keeping in mind the family-of-origin contexts in which they developed, holds a compassionate stance—modeling ways partners can be compassionate with each other in these tender explorations. This intergenerational exploration softens couple dynamics, as partners visualize each other as young children growing up with wounds, frustrations, or losses.

"GROWING UP" SURVIVAL STRATEGIES

Survival strategies are self-protective mechanisms developed in childhood to adapt to family-of-origin circumstances. Different siblings may utilize different survival strategies: One may be the caretaker, another the rebel; and a third, the entertainer. These survival strategies are carried into adulthood, often in a form frozen in childhood. In the couple relationship, when threatened, partners act much as they did as in their family of origin. The therapist helps clients shape their survival strategies to become more flexible and adaptive in the adult context. Clients can *choose* when and how to utilize survival strategies rather than being driven by them. One client routinely became defensive when his partner talked about an upsetting interaction. The therapist asked him to think of his defensiveness as a shield that he could choose to wear or put down as needed. This exercise allowed him to be in charge of his defensiveness rather than his defensiveness driving his reactions.

SPEAKING FROM VULNERABILITY

Clients are encouraged to speak directly from vulnerability rather than react from survival strategy. Confiding in the partner about one's softer feelings—coming *to* the partner—tends to evoke empathy; coming *at* the partner with accusations or criticism evokes defensiveness and counterattack.

THE FORK IN THE ROAD

Couple therapy often involves "Monday morning quarterbacking," with clients reviewing a fight or impasse and considering what they might do differently in the future. (The therapist helps each partner identify what *they* could do differently, not what the *other* should do differently.) In retrospect, they identify how their vulnerabilities and survival strategies got activated. Eventually, clients learn to catch themselves in the middle of the action, note when they're starting to get triggered, and make a different choice. The therapist asks clients to imagine a fork in the road: The well-trodden path leads to habitual self-protection, other-blaming, and the inevitable impasse. The other path entails self-awareness and choice. Clients are pleased when they can choose the new path, which usually evokes positive responses from the partner. It will take many repetitions of this new behavior for it to become wired into the brain as a new habit; imaging the fork in the road is the start of that process.

Linking the Present and the Past: The "Magic Question"

As the couple draws their vulnerability cycle diagram and identifies their vulnerabilities and survival strategies, the therapist helps them connect their individual hurts and self-protective mechanisms that fuel the cycle to unresolved issues from their families of origin. I now explore more specifically ways of identifying and healing intergenerational wounds.

When the couple is at a particularly intense impasse, I pose what I call "the magic question": "Is this experience you're having right now with your partner familiar to you? Have you felt this way earlier in your life?" Jamal feels disregarded by his partner Marcus when he asks for help in the house. Jamal, overburdened in their division of labor, claims that Marcus doesn't pull his weight. The impasse occurs when Marcus turns away and shuts down in response to Jamal's (admittedly accusatory) request for help, leaving Jamal feeling ignored and disrespected. The therapist asks, "Jamal, is it familiar to you, what you're experiencing with Marcus, that you're feeling overwhelmed, and when you state your needs, you feel ignored? Did that happen to you earlier in your life?" Jamal recalls that his mother, a single parent, worked two jobs, leaving Jamal in charge of housework and care of his siblings. When Jamal objected, which was rare, his mother called him selfish; in light of her own burdens as an African American woman who grew up in poverty, she expected her son to do what he was told and not complain. Now, when Jamal feels overburdened, those old feelings from childhood are reactivated, and when Marcus turns away from his pain, Jamal's sense of being disregarded as a child is also triggered. Jamal further reflects on feeling disregarded as a Black male in a racist society. He looks to Marcus to make up for the injustice he experiences in the larger social context.

Marcus is moved by Jamal's story. He knew that Jamal had grown up poor with a single mother and too much responsibility, but he had never made the connection between that experience and the couple impasse. As we explore the overlap between present and past (Scheinkman & Fishbane, 2004), both partners see the parallels. Marcus, who loves Jamal but is often preoccupied with his work as a lawyer, sees the damaging impact his turning away has on Jamal. In this conversation, Jamal feels heard. For the first time in his life, he feels he is getting through to someone he loves about his distress. The moment is transformative for this couple.

The therapist asks Marcus about his experience of being accused by Jamal, and whether it triggers memories from his own childhood. He responds that he always felt that whatever he did wasn't good enough. He grew up in a middle-class African American home, with his parents pushing him to succeed academically. His father was harsh and rejecting when Marcus told his parents he was gay. Marcus learned to tune out his parents to deal with the pain. He has always strived to prove himself worthy, especially as a gay Black man in a racist, homophobic society. He has looked to Jamal to accept him as he is. Witnessing Marcus's response to the magic question, Jamal feels compassion and sees how his criticism has been damaging to his partner.

I call this "the magic question" (Fishbane, 2019) because it often opens a door to new perspectives about a couple's impasse, transforming the interaction. Many painful and repetitive moments in couple interactions are enactments of old family dynamics; identifying links between present and past can be liberating. Witnessing the partner's pain and vulnerabilities from childhood tends to evoke compassion rather than anger. The impasse dissolves as the couple explores ways to interact that don't replicate their painful pasts. As with Marcus and Jamal, the magic question also opens doors to exploration of clients' experience of larger cultural traumas, exploitation, or oppression.

The question must be asked with respect and compassion, without blaming or shaming. As clients talk about their family-of-origin or larger contextual experiences, the roots of vulnerabilities and survival strategies emerge. These survival strategies were often adaptive early in life, although they are causing havoc in the couple relationship. When the therapist expresses respect for survival strategies as they evolved in the past, clients are more open to considering how to modify these strategies in their current relationships.

The magic question evokes new perspectives for both partners, especially when they haven't made the connection between their current impasse and childhood experiences. Partners often feel tender and protective toward each other; the tone in the room shifts as they become less defensive and more compassionate.

Some clients reply to the magic question, "I never felt this way with anyone else—only with my spouse!"—focusing on the injustice in the relationship and perhaps being stuck in blame mode. They may fear that if they explore personal overlaps between present and past, it points the blame at themselves, letting the partner off the hook. And while it may indeed be an impasse that only occurs in this relationship, there is typically some resonance between the current couple cycle and dynamics from each partner's past.

On very rare occasions, one might use information they heard about the other's family of origin for a weapon in the next fight ("You're so defensive because your mother was crazy! I'm not your mother! Grow up!!"). If this occurs, the therapist makes it clear that hearing each other's tender backstories is a privilege; using these revelations as weapons is destructive and contrary to the therapeutic contract of safety and respect. The office is a safe space to work toward healing, not harm. The couple is then given a choice whether to continue therapy—with the terms of safety and respect clear.

Differentiation

One of Bowen's great contributions to intergenerational family therapy was his concept of "differentiation of self." Bowen has been criticized for privileging individual autonomy over relational processes. Contextual theorists define identity more relationally, describing the "relational self," and noting that "self-delineation is a dialogic process" (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991, p. 203). Boszormenyi-Nagy and Krasner (1986) reconceptualized autonomy: "The individual's goal of autonomy is inextricably linked to his capacity for relational accountability. In fact, responsibility for the consequences of one's actions on his relational partners may be the true test of autonomy" (p. 62). Similarly, theorist-clinicians such as Monica McGoldrick, Betty Carter, Froma Walsh, Harriet Lerner, and Carmen Knudson-Martin have articulated Bowen theory in more relational terms. McGoldrick and Carter (1999) suggested that "maturity depends on seeing past myths of autonomy and self-determination" (p. 29), highlighting the "self in context" (p. 27). Here is their definition of differentiation:

> [Differentiation] consists of developing personal and authentic emotionally engaged relationships with each member of the family and changing one's part in the old repetitious, dysfunctional emotional patterns to the point at which one is able to state, calmly and nonreactively, one's personal view of important emotional issues, regardless of who is for or against such a view. It involves learning to see your parents as the human beings they are or were, rather than as your "inadequate parent," and relating to them with respect and generosity. (McGoldrick & Carter, 2001, p. 289)

Therapists usually focus on "differentiation *from* the family of origin"; however, "differentiation *with* the family of origin" is equally important (Fishbane, 2005). How one interacts with family members evolves throughout the life course, with both personal and relational adaptations. Coevolving new ways of relating with parents and siblings can be challenging. As therapists have long noted, the only person you can change is yourself. Trying to change one's partner, parents, or siblings is likely to fail. Yet changing one's own part in the dance does change the dance. Balancing self-determination with openness to family members and their concerns is not easy. To the extent possible, dialogue with family members is an essential part of the differentiation process (Fishbane, 2005). This more relational view of differentiation embraces the interplay between self-definition and relational codefinition—of one's self and the relationship.

These nuances of differentiation affect couples. People who focus on defining self on their own terms, over against others, may be guarded and self-protective in their relational life. This individualized view mirrors the hyperindividualistic values of the dominant U.S. culture; couples act out these values, defending their own views, rights, and identity from each other. By contrast, defining self vis-à-vis significant others—whether they be members of the family of origin or one's partner—can be a creative relational process, in which both parties consider how they impact each other (Carlson & Haire, 2014). In this view, dialogue and relational ethics are as salient as autonomy and authenticity.

MAKING A RELATIONAL CLAIM

Having voice—articulating one's needs and perspectives—is a key aspect of differentiation. If partners were not encouraged to have voice in their families growing up—if they were silenced, disregarded, or intimidated—in the couple relationship now they may engage in adversarial power over struggles when they speak up by putting the other down (Atkinson, 2005). These "fallback measures" are counterproductive, since most partners want to get through to each other (Wile, 2002). The therapist helps clients "make a relational claim" (Fishbane, 2013)—having voice while also attuning to the concerns of the other and holding the well-being of the relationship in mind. Many clients don't feel they have the right to speak their needs; they either silence themselves or erupt in anger. Speaking authentically while respecting the partner is a complex skill.

The therapist helps the couple develop skills of relational empowerment—Power To and Power With—so they don't have to resort to Power Over behavior (Fishbane, 2011). Power To is the ability to be the person one wants to be and live up to one's own values. It includes emotion regulation, thoughtfulness, having voice and agency. Power With is the ability to share power, make room for multiple perspectives, and co-create a relationship of respect, trust, and fairness. Power With also entails empathy, generosity, and care.

These skills are key to differentiation in both intergenerational and couple relationships. Clients stuck in a Power Over mode with parents—feeling disempowered or asserting power (e.g., by threatening to withhold contact with grandchildren)—are likely to re-enact Power Over dynamics with their partner. Changing how one relates to parents and siblings often leads to changing one's stance in the couple relationship. And changing one's stance changes the dance.

Boundaries

Bowen theory focuses on boundaries—ideally, clear and strong, but not rigid. Boundaries are often seen as mechanisms for self-protection, to keep other people out. But healthy boundaries also enable safe connection (Jordan, 2010). Without good boundaries, empathy can be risky, as one can get lost in the other's pain (a particular challenge for many women). Boundary between self and other is a core component of empathy according to neuroscientists (Decety & Jackson, 2004). Working on healthy boundaries is important in both couple and intergenerational therapy. The therapist needs to take into account clients' cultural values around boundaries, which can vary significantly.

THE FENCE EXERCISE

This imagery exercise (Fishbane, 2005) is particularly helpful with intergenerational boundaries. Eva, who immigrated as a young girl from Mexico with her parents and sister, has a hard time setting limits with her mother Maria. Eva gets upset with her mother's frequent phone calls complaining about various family members. Eva (herself a therapist) offers advice, which Maria never takes. Eva feels obligated to answer her mother's phone calls even when it's not a good time. Eva alternates between overaccommodating and losing her temper, angrily blaming her mother, then feeling guilty for being a "bad daughter."

The therapist asks Eva to imagine that her mother is a neighbor, with a fence between their yards. Over the fence, Eva sees her neighbor's yard. It's a mess: sunflowers planted in the shade, and shade grass in the sun. Eva, a seasoned gardener, offers planting tips to her neighbor, who doesn't take her advice. Eva can still enjoy her summer, and her own lovely flowers—as long as she remembers that her garden is on her side of the fence, and the neighbor's is on the other side.

Eva is intrigued by the exercise; she uses it successfully the next week. When Maria calls to complain about Eva's sister, instead of getting reactive, Eva, picturing her mother as a neighbor, offers sympathy without giving advice or taking sides. Eva says, "I put my mother on her side of the fence; and I didn't feel angry or helpless. I actually felt more compassion for my mom. I didn't take on her problems as my own. It was a great relief." With a healthy boundary, Eva can now afford to be more compassionate with her mother.

BE RESPONSIBLE *TO* YOUR FAMILY, NOT *FOR* YOUR FAMILY

This maxim, suggested by McGoldrick (2016), makes an important distinction, especially for overresponsible adult children. Prior to the Fence Exercise, Eva felt responsible to make her mother happy and solve her problems. She inevitably failed. In therapy, Eva realized that she is not responsible *for* her mother's happiness or unhappiness; she is only responsible *to* her family to be the best Eva she can be. This shift calmed Eva's inner turmoil of anger, blame, and self-reproach that had kept her stuck with her mother. This same dynamic played out in Eva's marriage. When her husband was in a bad mood, Eva felt it was her job to fix his problem and lift his spirits. She often failed, becoming angry at her husband and self-critical for failing. Eva came to see that she could be responsible *to* her husband for her own actions but was not responsible *for* his moods. Their relationship improved as she gave him space to work through his own feelings, without pressuring him to be happy.

"Growing Up" Relationships with the Family of Origin

LIVING UNDER THE SPELL OF CHILDHOOD

Many adults are "living under the spell of childhood" (Fishbane, 2005), seeing parents from the viewpoint of a young child, hoping that parents will one day give them what they need. The parents have all the power, and the adult child is helpless. This stance fuels reactivity and resentment. The adult child may not be aware of developments in parents' lives, the ways parents have grown, mellowed, or even gone to therapy themselves. Living under the spell of childhood is constraining and disempowering for the adult child.

WAKING FROM THE SPELL OF CHILDHOOD

The therapist helps clients "grow up" their views of the family of origin and "wake from the spell of childhood" (Fishbane, 2005), seeing parents as real people on their own life journey (Framo, 1981), with their own vulnerabilities and survival strategies. This process is facilitated by learning family stories from prior generations, understanding the contexts in which parents grew up.

One of the most striking quotes from intergenerational family theory is: "Think of your mother as your grandmother's daughter and get to know her that way" (Michael Kerr, personal communication, 2003). The client is invited to be curious (and, where possible, to ask) about parents' own experiences growing up in their families of origin. The parents were once children who did the best they could to survive in their own families. The therapist helps clients shift from a *hierarchical* view of parents to a *generational* view (Fishbane, 2005). In a hierarchical view, parents have power to give or withhold what the adult child needs, with the adult child helpless and often angry. The generational view is more compassionate: Parents were once children who survived in their own families of origin and larger cultural context, and now are doing the best they can. In this multigenerational story, the client may also be a parent, making their own mistakes and hoping for understanding and forgiveness from their children. The generational view goes back multiple generations and extends into the future, toward one's children and beyond.

Waking from the spell of childhood and going beyond power struggles with the family of origin often have positive impacts on the couple relationship, as partners relate to each other and their families with greater maturity and differentiation.

THE STORIES WE TELL

In relationships with one's partner or family of origin, narratives can be constraining. Viewing parents as real people helps to shift the story, visualizing them in the context of their own multigenerational family experiences or sociocultural traumas such as immigration, war, or oppression. Naomi learned as an adult that her mother Jeannette had experienced losses and trauma in the process of immigrating to the United States from Poland in her early teens. Jeannette had never reckoned with her past, looking to her daughter, her only child, to give her the love she lacked in her own childhood. This dynamic intensified when Naomi's father died young. Before learning her mother's fuller story—Naomi had been given a sanitized version by Jeannette of an idyllic childhood and immigration experience—this daughter harbored resentment toward her mother for leaning on her to make her happy; Naomi was a parentified child (Boszormenyi-Nagy & Spark, 1973). Once Naomi heard Jeannette's complex story of loss and trauma, including the murders of members of her family of origin in the Holocaust, Naomi had renewed respect for her mother and gratitude for all Jeannette had done to create a new and secure life for Naomi. No longer driven by anger, Naomi was able to choose how to be in relationship with her mother—including setting limits with love instead of reactivity. She shifted from a parentified child role to a position of thoughtfulness in the intergenerational relationship. This family-of-origin work helped Naomi in her marriage as well. Before, she had bristled when her husband looked to her for love and affirmation, feeling that he was too needy. In therapy, Naomi saw the connection between her reactivity to her husband and her feelings as a parentified child. Transforming her view of her mother helped Naomi to see her husband more compassionately. In both relationships she was freer to be generous, while also setting limits.

THE "LOVING UPDATE"

Contextual therapy, where possible, promotes "rejunctive action" (Boszormenyi-Nagy & Ulrich, 1981) in the intergenerational family: addressing not only stories but also the relationships themselves. The therapist helps clients update or "grow up" current relationships with family of origin. If one member of a couple is stuck in a distancing or resentful stance with their parents, and if that dynamic is being enacted as well in the couple relationship, the therapist might encourage greater openness and curiosity toward the parents. Assuming there is no current risk of danger (the parent is not violent, mentally ill, or abusing substances), this may take the form of a "Loving Update" meeting between adult child and parents. Such a meeting should not occur when clients are actively angry at parents, but only after they have been able to reflect with some compassion on parents' own life journey, including the backstory of parents' childhoods. The partner is not invited to Loving Update meetings with parents, as that complicates the dynamics. Clients are encouraged to share with their partner before and after the meeting.

The intergenerational meeting happens either in the therapist's office or "out there," with the client initiating a get-together with parents, perhaps inviting them to lunch. In either case, the therapist coaches the client, planning and anticipating parental reactions, and extending multidirected partiality to parents as well as client. If parents are coming into a conjoint session, the therapist first works out ground rules with the client. While the adult child might share with parents in the session some of their struggles in the relationship, this is not to be a blame fest. Furthermore, it is important to extend a warm welcome and help parents feel comfortable, since they are coming into their adult child's therapy. The therapist makes it clear that extending a welcome to parents is not an abandonment of the client, nor is it a challenge to the client's story of hurt in their childhood. Multidirected partiality, by definition, is not a zero-sum game.

In the conjoint session, the therapist thanks parents for coming, indicating that they are a valuable resource. The adult child sets the tone of constructive mutual exploration. Parents are invited to reflect on the current relationship with the adult child, as well as recall stories about the client's childhood and family dynamics when the child was growing up. Parents are also encouraged to talk about their own experiences in their family of origin, and how that influenced their parenting. In these discussions, it is not uncommon for parents to share family secrets, losses, or traumas, which helps the adult child gain a deeper understanding of family dynamics.

If a client chooses to have the update conversation with parents on their own, not in the therapist's office, the therapist coaches the client on how to invite parents in a respectful rather than accusatory manner. It is not helpful for adult children to "share" with parents what they've learned in therapy about parents' mistakes in raising them. Accusations beget defensiveness, which defeats the purpose of the meeting. Rather, the adult child extends the invitation saying, "I love you, Mom and Dad, and I'd like us to have a better relationship. I know I've been pretty distant with you." If this "love" language is uncomfortable for the client, another option is: "I'd like us to have a better relationship. Would you be willing to go to lunch and discuss how we might do that?" Or the client might ask for the parent's help: "I'm working on my anxiety in therapy, and I could use your help. Can we meet to talk about it?" If the adult child has been keeping parents at arm's length, parents are often relieved to be invited to connect and be supportive. When the invitation is warm rather than judgmental, most parents respond positively.

Lerner (1985), building on Bowen theory, addressed the "three-step dance of change": The adult child makes a new move in consultation with the therapist, anticipates the parent's response, and plans a next move. While this may sound strategic, rather like a game of chess, it does not have to be manipulative. Planning gives the client a way forward if parents are defensive or don't respond to an initial change on the part of the client. Many clients try to change their interaction with their family of origin, only to be disappointed by the response. They tell their therapist, "I told you it was hopeless! These people will never change!" Planning constructive responses to anticipated parental reactions can keep the process moving forward in a positive direction. It is crucial that these meetings not devolve into an attempt to change family members—although, as noted, one person changing their part in the dance often changes the dance.

The Loving Update conversation includes joint reflections on the current relationship between parents and adult child; the client's childhood and family dynamics; the parent's own experiences growing up; and how each would like the relationship to look moving forward. The most moving moments are when parents share information, lore, or secrets going back generations. New perspectives gained from these conversations can transform the parent–adult child dynamic.

Discussions about expectations, roles, and boundaries are also part of the process. How often does each want to visit? How can they reach out to each other and also set limits in a respectful way? How do they deal with disappointments? What are expectations around in-law relationships? Even if both sides work to improve the intergenerational connection, it is likely that parents and adult children will fall back into old habits of reactivity at some point in the future. The Loving Update includes planning for ways to get back on track if this happens. The Loving Update is not a one-time event. It is the beginning of an ongoing intergenerational dialogue.

The Loving Update positively affects not only the intergenerational relationship but also the couple. The adult child who is able to hold their own with parents, engaging clearly but respectfully, is developing skills that serve them well in the couple arena as well.

REPAIR: GUILT, APOLOGY, FORGIVENESS, ACCEPTANCE

While the Loving Update is not a blame fest, often there are wounds (on both sides of the intergenerational relationship) that are addressed. Guilt may be aroused as old hurts are discussed. Many people are allergic to guilt, becoming defensive when they see that they have hurt another. We have noted Buber's (1957) distinction between healthy and neurotic guilt. Healthy guilt allows one to take responsibility, apologize, and offer amends—actions that can be liberating and reparative for the relationship.

In an ideal scenario, parents are able to take responsibility for their behavior in the past and apologize, facilitating the process of forgiveness. Likewise, some adult children are able to acknowledge the ways they have hurt their parents. Yet many individuals who were forced to apologize as children may find it difficult to apologize in adult relationships. Other clients find it difficult to forgive, even after an apology. Psychologists have identified the benefits of forgiveness for mental and physical health of the person forgiving, and the damaging effects of chronic anger (Worthington & Scherer, 2007). Spring (2004) offers an intriguing perspective on forgiveness. When both parties explore the hurt between them, with the one who hurt the other taking responsibility and apologizing, and the hurt one accepting the apology and letting go of anger and blame ("genuine forgiveness"), a process of meaningful repair can take place. But what if the one who hurt the other refuses to take responsibility? Spring notes several options for the hurt party in this scenario. One is refusing to forgive, which is problematic because of the negative effects of chronic anger on mental and physical health. Another option is unilateral forgiveness, which can put the forgiver in harm's way if the other hasn't taken responsibility or committed to change. Spring offers an intriguing alternative: acceptance. Acceptance entails putting down the burden of anger and resentment, even if the other hasn't taken responsibility. While not as robust as genuine forgiveness, acceptance allows the hurt person to understand the other and their limits, and to move forward without staying stuck in chronic resentment. One may or may not choose to continue in the relationship, depending on how egregious the violation was and how safe it is to engage now. But one doesn't have to be angry forever.

Acceptance is a vital aspect of repairing intergenerational wounds even in the absence of a full, mutual process of repair. One doesn't have to be a victim or carry chronic anger that can be so corrosive. Accepting parents' limitations and deciding how much contact to have with them (assessing the current level of risk) allows the adult child to let go of the victim position. Acceptance is a vital practice in all relationships, as one sorts out what to accept and what to protest, or when a relationship is too toxic for acceptance. A helpful mantra for family relationships is "Take the best and leave the rest" (Fishbane, 2013), appreciating the good aspects of a relationship and not focusing on the negative—without, of course, putting up with abusive or offensive behavior. This form of acceptance is also key for couples, as partners learn to accept differences and sort out what one can or cannot accept in the other.

The dynamics of repair in intergenerational relationships—guilt, apology, forgiveness, compassion, acceptance—are at play in the couple relationship as well. As clients develop skills for intergenerational repair, these same skills are applied with the partner. The impact works the other way as well; as partners become more adept at repairing within the couple relationship, they can bring these skills to relationships with their parents and siblings.

GRATITUDE AND GENEROSITY

The human brain is biased toward noticing the negative, with the amygdala constantly scanning for danger. This negativity bias plays out in couple relationships, as unhappy partners notice problems and overlook the positive (Gottman, 2011). Likewise, in intergenerational family relationships, the adult child may focus on the negative with parents or siblings. Without denying problems, the therapist helps clients also notice the positive, or "resources of trustworthiness," in their family of origin (Boszormeni-Nagy & Ulrich, 1981). An adult son says, "I know my father loves me, but he drives me crazy with his advice." The therapist asks him to pause and notice "my father loves me"—a resource he is taking for granted. As he acknowledges his father's love, his work on intergenerational boundaries becomes less fraught.

Some families, cultivating awareness of the positive and the practice of gratitude, create a "Blessings Jar": noticing positive actions of family members over the course of the year, jotting them down on a piece of paper, and putting them in a jar. At Thanksgiving, the family members open the jar and read all the notes. Some couples do the same, perhaps on a more frequent basis. This ritual trains the brain to notice the positive and cultivate the habit of gratitude.

Generosity is closely related to gratitude. Aside from the obvious expressions of generosity (with one's time or money), generosity is embodied through giving another the benefit of the doubt, or "the least pathology assumption." This practice can be transformative in couple and family relationships.

Family-of-Origin Relationships Evolve over the Life Cycle

Intergenerational maturity and differentiation are not achieved once and for all; they are ongoing processes throughout the life cycle. Differentiation poses different tasks for an adolescent than for an adult; becoming a parent, one faces challenges of differentiation with one's children, especially as they mature and build their own lives. Differentiation toward parents as they age also shifts, as do intergenerational boundaries if parents need more support when they are ill or frail. One never "gets there," is never finished: Differentiation is an ongoing and dynamic process of balancing one's own needs and perspectives with those of parents, siblings, partner, and children.

As parents age, adult children may be called on to help or offer care; often, it is a daughter who is the primary caregiver of aging parents. If one sibling is carrying the entire burden, she may become overwhelmed and resentful. Walsh (2016) suggests "caregiving teams," with siblings supporting each other and taking turns helping out. The caregiver's burden is lightened when parents are grateful and siblings supportive; it can become unbearable if parents are critical or siblings are judgmental. If parents have physical, emotional, or cognitive limitations, the caregiving burden can become intense. Balancing loyalty and concern for parents with allegiance and availability to one's partner or children can be challenging. A couple relationship may become strained when one partner is critical or jealous of the other's devotion to parents. While caring for aging parents is at times burdensome and often complex, it can also be a privilege, an opportunity to grow personally, relationally, and spiritually (Fishbane, 2009, 2019).

Parents' deaths are part of the intergenerational life cycle. If there is unfinished business, the loss can be traumatic. Boszormenyi-Nagy advises adult clients whose parents are alive to imagine standing at their parents' graves in 10 years, think about what they would regret not having said or done, and work through these issues now, while parents are still alive. Where possible, resolving intergenerational issues while parents are alive enhances both family-of-origin and couple relationships.

On the parents' side, thinking through the legacies they are leaving their children is important. Have they been able to bless their children, recognizing each as a valued individual? If parents leave an estate that favors one child over others, they may stir up resentments between the siblings from the grave. An old history of sibling rivalry or parental preferences for one child complicates family dynamics at this time of life.

While this chapter focuses mainly on adult child–parent relationships as they impact couples, sibling dynamics may also be lived out between partners. For example, an eldest, parentified sibling may be stuck in an overresponsible role in a marriage, feeling resentful toward their spouse like they felt toward their sisters and brothers. If one felt silenced or overlooked by siblings, that resentment may also carry forward into a couple relationship. Whether with parents or with siblings, developing a more complex view and more adaptive coping mechanisms can benefit the couple, as well as intergenerational family relationships.

MECHANISMS OF CHANGE

Successful couple therapy facilitates personal responsibility, as partners see their own role in the dance, exploring vulnerabilities and survival strategies; clarify higher values and goals; and identify blocks to being their best self relationally. The key shift is from blame to self-responsibility. This includes developing skills of emotion regulation, empathy, and repair. Shifting from blaming to co-responsibility is paralleled by shifting from Power Over to Power To and Power With. A focus on relational ethics helps the couple explore their balance of fairness, and the ways they impact each other for better or worse.

To accomplish these goals, the therapist helps clients work through old wounds from the family of origin. Understanding parents in their own intergenerational context allows clients to see them more realistically and compassionately, and where possible, to repair relationships with parents and siblings. This intergenerational work positively impacts the couple, as partners let go of burdens and resentments from the past that are reenacted in the couple context. In the process, they shift from a victim stance—feeling victimized by the partner and/or parents—to a stance of empowerment, as they choose who they want to be in the couple relationship.

Insight, behavior change, and emotional-experiential processes are key mechanisms of transformation. The therapeutic alliance is central to this work: The therapist's respect and multidirected partiality are necessary for partners to risk exploring their roles in the impasse. Individual dynamics, relational patterns, and intergenerational-systemic processes are addressed, as well the larger social context in which the couple and intergenerational family are embedded.

Clients come to therapy to change; yet, at times, they "resist" therapeutic interventions. The ambivalence around change is reflected in the human brain. Habits are supported by circuits of neurons: The stronger the habit, the stronger the neuronal circuit. Survival strategies from childhood become habitual, and couples enact their dances on automatic pilot. Change is possible, though harder in adulthood; research indicates that neuroplasticity continues throughout life (Gage, 2004). Therapists and couples work to identify new habits and behaviors that reflect clients' higher values. New habits must be practiced over and over in order to become incorporated into new neuronal circuits. The therapist offers "neuroeducation" about the process of developing new relational habits, and the role of repetition for these habits to become automatic.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

This treatment approach is applicable to most couples; it does not, however, specifically address issues of violence, serious mental illness, addiction, or affairs, which may require referral to a therapist who specializes in these issues. Furthermore, direct engagement with parents or siblings requires a risk assessment. If parents or siblings are currently violent or volatile, it may be unsafe to hold actual meetings. Some parents may be unwilling to engage with their adult child in a conversation about their relationship, or they may be defensive, rejecting any responsibility. Nevertheless, developing a deeper understanding of intergenerational legacies, traumas, and unfinished business is possible even in such circumstances. If parents are dead, Loving Update conversations are no longer possible. Yet it is still advisable for clients to learn more about their parents as real people through interviews with relatives or friends, or through letters or Internet searches. In treating adult survivors of childhood abuse, the therapist needs to work carefully, reflecting the injustice done to the client early in life. Contextualizing parents' limitations should on no account be confused with whitewashing or condoning damaging behavior. Referral to a trauma specialist may be advisable.

Therapists using interventions such as the Loving Update need to take into account the cultural values of clients and their intergenerational families. A meeting that promotes mutual exploration and negotiation of roles and expectations may not be appropriate for families whose cultures discourage such explicit conversations or airing of differences. In such situations, a more indirect approach to updating intergenerational interactions may be necessary.

Intergenerational psychotherapies have only rarely been the subject of research. However, the work described in this chapter does build on findings from interpersonal neurobiology, intergenerational transmission of trauma and epigenetic changes, and studies of adverse childhood experiences. Also relevant to this approach is research on relationship satisfaction, differentiating happy from distressed couples (Gottman, 2011), and studies of emotion regulation and reactivity (Gross, 2015). With regard to the therapist's stance of multidirected partiality, the alliance is central in all psychotherapy; a balanced alliance is crucial in couple and family therapy (Friedlander, Heatherington, & Escudero, 2016).

CASE ILLUSTRATION

Mark and Diana come to couple therapy because of escalating fights. They are a White, mixed-gender couple in their mid-40s, married for 20 years, with two children: Amelia, 18, who recently left for college, and David, 13. Mark is a senior research scientist at a university, and Diana is an artist and stay-at-home mom. They describe a typical fight: Mark comes home after a stressful day at work, looking forward to peace and quiet. Instead, he finds chaos as he enters the door. Shoes and coats are strewn on the floor in the front hall, and he hears the raised voices of his wife and son in the kitchen. Mark gets agitated as he enters the kitchen and sees Diana and David fighting over David's math homework. He walks in, highly critical of both wife and son. Diana, stung by the criticism and exhausted from struggling with David, gets defensive and angry, calling her husband "anal." Mark storms out of the room and goes into his study, slamming the door behind him. David tunes out both parents and escapes to his room.

This couple is enacting a dance that is painfully familiar to them: Mark criticizes; Diana defends and gets angry; Mark withdraws. Each blames the other; Mark blames Diana for the mess and chaos, and for being mean when he registers his upset; Diana blames Mark for being unappreciative of all she does for their son, for being aloof as a parent, and for criticizing and abandoning her by stomping off.

Initiating Therapy: Why Now?

Mark and Diana's differences are not new. When they first met, he was attracted to her free spirit and emotional expressiveness, and she was drawn to his quiet steadiness. But over the years, they have become polarized and resentful over their differences. Things came to a head recently when their daughter Amelia left for college. Amelia is organized and academically gifted like her father; she is very close with her mother and helpful with her little brother. Amelia's absence is destabilizing for everyone. David, who was always a bit disorganized, is now in middle school, with increased academic pressure. Recently diagnosed with attention-deficit/hyperactivity disorder (ADHD), he is not yet on medication. The couple is seeking therapy because they are distressed about the state of their marriage and its impact on David, who is increasingly withdrawn and angry.

The Blame Game: Multidirected Partiality

Mark and Diana come to therapy, each feeling like a victim. They look to the therapist to judge whose fault it is when they get into this impasse. The therapist does not accept the role of judge, holding instead a stance of multidirected partiality, siding with both partners, and acknowledging that both are in pain; their impasse is harmful to them and their son. The therapist congratulates them on having the courage to come to therapy to work on their relationship.

Therapist and couple explore the circular nature of their dance: The more he criticizes, the angrier she becomes; the angrier she becomes, the more he withdraws. The partners are encouraged to identify their roles in the dance. Both are victims of this repetitive interaction, and both are inadvertent coauthors of it. The blame game leads nowhere, and is disempowering and hurtful to both. From the beginning, the therapist helps them shift the discourse from blame to empowerment and coresponsibility. This sets a tone of curiosity and respect, making room for the experiences and narratives of both partners.

The Vulnerability Cycle Diagram

Exploring their dance helps Mark and Diana identify how each becomes self-protective when threatened, as their survival strategies of criticism, defensiveness, anger, and withdrawal get activated. What are the vulnerabilities fueling these survival strategies? Vulnerabilities are not immediately apparent; they emerge over the first few sessions. The therapist draws the vulnerability cycle diagram together with the couple (see Figure 9.1).

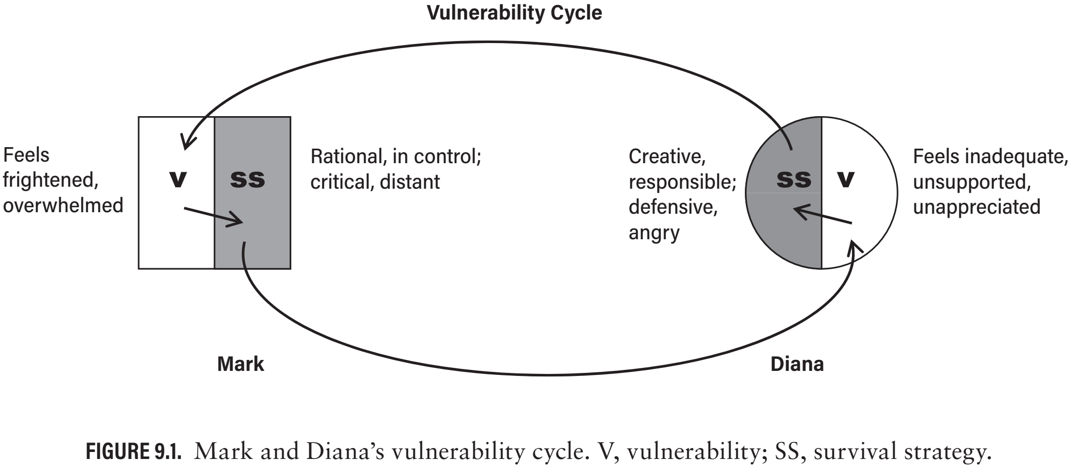
Some survival strategies are characteristics of each partner that don't necessarily contribute to the impasse: Mark's rationality and desire to be in control (as long as they do not become extreme), and Diana's creativity and sense of responsibility. But as their vulnerabilities are stirred through the interaction, the survival strategies that fuel the dance are triggered: his criticalness and withdrawal, her defensiveness and anger.

Drawing the vulnerability cycle helps this couple identify "the dance we do together." They are invited to look at it as a team rather than blame each other. As they start to think how each can intervene in the cycle to change it, they are shifting from victims to coauthors, and from defensiveness to responsibility.

While the vulnerability cycle is co-created as each protects self from other, there are power differentials that impact their interaction. Both secure financially, Mark and Diana are not carrying traumas or inequities based on racism or other sociocultural stressors. But like many heterosexual couples, they are impacted by the effects of patriarchy and gendered power imbalances. Mark is the main wage-earner for the family, while Diana has raised the children. There is considerable inequity in their incomes. Mark embodies male entitlement, with expectations for how his wife and son should behave. Diana feels a sense of responsibility and guilt as a mother, blaming herself for their son's difficulties. As the therapist helps the couple address coresponsibility for their cycle, the complexities of sociocultural inequities must be taken into account.

The Magic Question: Intergenerational Wounds Fueling the Vulnerability Cycle

The therapist asks Mark, "Is it familiar to you, this sense of distress over the mess and emotional volatility when you come home? Have you felt this way before, earlier in your life?" Mark becomes emotional, his tight control giving way to more tender feelings as he makes connections between past and present. Mark grew up shar-



Vulnerability Cycle
Feels frightened, overwhelmed
V
SS
Rational, in control; critical, distant
Creative, responsible; defensive, angry
SS
V
Feels inadequate, unsupported, unappreciated
Mark
Diana

FIGURE 9.1. Mark and Diana's vulnerability cycle. V, vulnerability; SS, survival strategy.

ing a room with his older brother Larry, who left messes everywhere, which really bothered neatnik Mark. More ominously, Larry had frightening temper outbursts; Mark was upset that their parents didn't set limits on his brother. Larry was diagnosed with ADHD in late adolescence and bipolar disorder in his 20s. Mark vowed to himself that when he grew up, he would create a peaceful, orderly home with no shouting, no chaos, and no mental illness. As Diana listens, she softens, seeing how the nightmare of Mark's childhood is being replicated in their family now. She had known that Mark's brother Larry was a handful, but Mark had not talked much about him, and they had little contact with Mark's family of origin. Diana and the therapist compassionately witness Mark's exploration of the connection between past wounds and the couple's impasse. Mark is relieved to share his story.

The therapist then asks Diana, "Is it familiar to you that you feel alone and overwhelmed with responsibility, and are criticized no matter how hard you try?" Diana describes her experiences growing up. She was the eldest of five children; both parents worked full-time to make ends meet, and Diana was left in charge of her younger siblings. She was expected to help them with homework, clean up after them, and start dinner. Diana was fun and creative with her younger siblings, playing games and entertaining them. But no matter how hard she tried, she could never please her mother, who was critical when she came home and saw toys everywhere and the children running wild. Mark immediately sees the connection between Diana's role in her family of origin and her position with David. He also sees the parallels between his criticism of Diana and her mother's criticalness.

These partners love each other. As similarities are explored between their families of origin and their own relationship, they become less accusatory and more compassionate, each witnessing the other as the young child they once were. They see how their own behavior replays wounds from their partner's past. Widening and deepening their understanding of the impasse, they became allies in healing rather than enemies.

Mark and Diana have been collecting damages for childhood wounds at the wrong address—from each other. Mark has expected Diana to keep a neat and clean house, with no emotional turmoil. He needed her to create a peaceful home to heal his childhood wounds, ensuring that their children were calm and organized. Mark's expectations—impossible to meet—have put Diana in the familiar position from her own childhood of being overresponsible and trying to please. She, in turn, has looked to Mark to appreciate and adore her, and has not been able to hear his frustrations about their son; she hears it as criticism, which stirs up old feelings with her mother.

Neither partner has worked through their childhood wounds, which they have been enacting in their relationship, with David also affected. As they explore unfinished business from the past that has been fueling their impasse, they become a team helping each other. The therapist helps them explore their interaction more collaboratively and develop a new shared narrative.

Transforming the Cycle

Mark and Diana are beginning to see their interaction with less accusatory and more compassionate eyes, holding awareness of their own and the other's vulnerabilities and survival strategies. The therapist helps them identify when their vulnerabilities are getting activated, encouraging them to speak from vulnerability rather than react from survival strategy. Diana tells Mark how overwhelmed and worried she is about David. Informed by patriarchy, Diana has assumed that it is the mother's job to raise healthy, happy children; she feels she is failing at this. She also articulates her wish for Mark to be more involved with David and to help him with his homework. The couple explores how Mark can join the "parenting team" rather than being in the outsider critical position.

Mark is pleased to join the parenting team; he has long felt excluded from the closeness between his wife and son, not knowing how to join them. He, too, has been following patriarchy's rules, hiding behind his busy job, and has felt helpless in the face of his son's difficulties—much as he felt when his brother would be messy or have rages in adolescence. Mark confides to Diana his fears that David might carry some of his brother's genetic tendencies for ADHD and bipolar disorder; he had expected Diana to prove this wrong and to "fix" David. Diana, eager to show Mark that she was a good mother, and fearful of his angry response when she failed, had been pressuring David to succeed in ways that were stressing him out. Mark's disapproval was damaging to David, and father and son had become estranged.

As the partners confide their vulnerabilities and fears to each other, their interaction softens. They are becoming allies rather than enemies. The therapist helps them work on emotion regulation, and on "growing up" their survival strategies. When Mark feels upset by chaos when he comes home, he learns to take a few deep breaths, then share his distress with Diana without blaming her. If things get intense between them, instead of storming off, he negotiates a break, indicating that he wants to resume the conversation when he's calmer. Diana, holding her husband in mind, tidies up before he comes home—out of love, not fear. When she feels hurt, Diana now confides this to Mark. She sees that calling Mark names is harmful and doesn't get her what she wants. Both practice mindfulness meditation to calm down. And they work on reappraisal—seeing the other as the beloved who is hurting rather than the enemy.

Growing Up Relationships with Family of Origin

In addition to looking with new eyes at their dance and childhood roots of their relationships with parents and siblings—"growing up" views of family members and addressing vulnerabilities and survival strategies, the therapist helps Mark and Diana consider their ongoing current family-of-origin relationships.

Mark rarely has contact with his parents or brother. He has blamed his parents for indulging Larry as a teenager, allowing him to spiral out of control. Mark sees the parallels between blaming his parents and blaming Diana for David's problems. Mark's views of his parents and brother are frozen from childhood. With little interaction with them, he has not seen the ways they have changed. The therapist encourages Mark to meet with his parents, either in a conjoint therapy session or by talking with his parents "out there," with the therapist coaching him in preparation. He chooses the second option. His parents are relieved to be invited to get together; they have long wished to heal the breach with their younger son. Mark is coached to come to this meeting with an open heart and curious mind, and to leave his resentments behind.

At the meeting, Mark's parents reflect on the strain of raising Larry, who was a handful starting in early adolescence; he developed bipolar disorder as a young adult. Mark shares how frustrated he was by Larry's messes, and how terrified he was of his rages. He talks about feeling unprotected and asks his parents why they didn't set limits on Larry's behavior. His parents, defensive at first, gradually relax and acknowledge for the first time the toll Larry's volatility had on Mark. They then disclose a family secret: Mark's mother had a sister who was emotionally unstable and later diagnosed "manic–depressive"; their parents were very hard on this sister, and she ultimately committed suicide. (The family story that Mark had heard was that his aunt died in a car accident.) When Mark's parents saw Larry exhibiting similar behavior, they were terrified of setting limits on him, lest he also kill himself. They compensated by overindulging Larry. The revelation of this family secret is transformative for Mark, as he comes to see the burdens his parents carried, which informed their parenting behavior. He also has greater compassion, since he understands the helplessness of a parent with a child with emotional difficulties, from his own experience as David's father.

Mark also reconnects with Larry, learning that he has been on medication for both ADHD and bipolar disorder for decades, is stable, and is doing relatively well. Mark considers ways to be in touch a bit more frequently with his parents and brother, working out mutual expectations and boundaries that are reasonable for both sides. Doing this family-of-origin work helps Mark feel less reactive and more compassionate as a son and brother; this in turn helps him be calmer and more connected with his wife and son.

Diana, moved by Mark's work and seeing how it is impacting him positively in their marriage and with David, decides to contact her parents as well. She invites them to a conjoint therapy session, sharing with them her ongoing sensitivity to being criticized. Diana's mother Sherry reflects on the intergenerational history of criticism in their family. Sherry's mother was highly critical of her for working after she had children, accusing her of being a bad mother. Sherry was determined to prove her mother wrong and leaned heavily on Diana to help her create perfect children. When Diana failed to do so, Sherry became highly distressed and critical, feeling that it reflected badly on her. Sherry apologizes to Diana for putting too much responsibility on her when young. This apology is moving to Diana. Hearing Sherry's backstory of her relationship with her own mother, Diana softens and becomes more compassionate. Sherry and Diana make a pact to stand up to criticism in their relationship. They agree that Diana can tell her mother when she feels criticized, and vice versa—in the service of connection. Diana's father Lance, who has always been reserved and distant, is less available for exploring feelings in this family-of-origin meeting. Nevertheless, he does shed some light on his own background, telling Diana that his parents never got along, with his mother blaming his father for being a poor provider. Lance determined that he would be a good provider for his family. He became totally absorbed in his work; he was exhausted when he came home and rarely available to his children. While Lance doesn't show much interest in renewing a relationship with Diana, his reflections on his past help her contextualize her sense of isolation from him—which had gotten replicated in her own marriage.

Less constrained by old grievances and intergenerational wounds, Mark and Diana's own relationship continues to improve. They work together to include Mark in parenting. Mark steps up to the plate with his son, no longer feeling helpless with David, as he had felt with his brother. This is a win–win–win for this family: Mark is not stuck in the outsider position; Diana is not overwhelmed as sole parent; and David feels closer to his father.

How Much Can Clients Change?

Mark and Diana are not totally transformed. He still prefers order and calm; she is still more emotionally expressive and disorganized. These differences are unlikely to change dramatically. But the partners are less polarized around their differences, less blaming, and more compassionate. The change in perspective with regard to their intergenerational relationships extends to a change in their own interactions. The therapist helps them plan for moments when they might revert to their old dance—Mark irritated by mess or escalated emotions, Diana defensive and angry. Indeed, these moments do occur when they get into conflict. But they have learned to catch themselves, utilize skills they learned in therapy, and recommit to their higher goals.

CONCLUDING COMMENTS

We are never fully free of old issues from childhood; vulnerabilities and survival strategies don't disappear. Life is messy, and humans are emotional and often irrational creatures. But doing this intergenerational work allows us to greet our old issues when they appear at our door as guests rather than as threatening enemies. Inspired by the poet Rumi (2004), we might invite them in and ask why they've come to visit. Engaging these old wounds and vulnerabilities with reflective curiosity and compassion ensures that they won't take over the whole house. They've just come to visit from the past. And perhaps we can learn from our visit with them.

SUGGESTIONS FOR FURTHER STUDY

Fishbane, M. D. (2013). *Loving with the brain in mind: Neurobiology and couple therapy*. New York: Norton.

Fishbane, M. D. (2019). Healing intergenerational wounds: An integrative relational-neurobiological approach. *Family Process, 58,* 796–818.

McGoldrick, M. (2016). *The genogram casebook: A clinical companion to genograms: Assessment and intervention*. New York: Norton.

Scheinkman, M., & Fishbane, M. D. (2004). The vulnerability cycle: Working with impasses in couple therapy. *Family Process, 43,* 279–299.

Website (with videos): *www.monafishbane.com*

REFERENCES

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. New York: Basic Books.

Atkinson, B. (2005). *Emotional intelligence in couples therapy: Advances from neurobiology and the science of intimate relationships*. New York: Norton.

Bateson, G. (1988). *Mind and nature: A necessary unity*. New York: Bantam.

Bloch, L., Haase, C. M., & Levenson, R. W. (2014). Emotion regulation predicts marital satisfaction: More than a wives' tale. *Emotion, 14,* 130–144.

Boszormenyi-Nagy, I., Grunebaum, J., & Ulrich, D. (1991). Contextual therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 2, pp. 200–238). New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. (1986). *Between give and take: A clinical guide to contextual therapy*. New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Spark, G. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy*. New York: Harper & Row.

Boszormenyi-Nagy, I., & Ulrich, D. (1981). Contextual family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 159–186). New York: Brunner/Mazel.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Aronson.

Buber, M. (1957). Guilt and guilt feelings. *Psychiatry, 20,* 114–129.

Byng-Hall, J. (2004). Loss and family scripts. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss: Death in the family* (2nd ed., pp. 85–98). New York: Norton.

Carlson, T. S., & Haire, A. (2014). Toward a theory of relational accountability: An invitational approach to living narrative ethics in couple relationships. *International Journal of Narrative Therapy and Community Work, 3,* 1–16.

Champagne, F. A. (2008). Epigenetic mechanisms and the transgenerational effects of maternal care. *Frontiers in Neuroendocrinology, 29,* 386–397.

Decety, J., & Jackson, P. L. (2004). The functional neuroarchitecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3,* 71–100.

Faulkner, W. (1975). *Requiem for a nun.* New York: Vintage.

Fishbane, M. D. (1998). I, thou, and we: A dialogical approach to couples therapy. *Journal of Marital and Family Therapy, 24,* 41–58.

Fishbane, M. D. (2005). Differentiation and dialogue in intergenerational relationships. In J. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 543–568). Hoboken, NJ: Wiley.

Fishbane, M. D. (2009). “Honor your father and your mother”: Intergenerational values and Jewish tradition. In F. Walsh (Ed.), *Spiritual resources in family therapy* (2nd ed., pp. 174–193). New York: Guilford Press.

Fishbane, M. D. (2011). Facilitating relational empowerment in couple therapy. *Family Process, 50,* 337–352.

Fishbane, M. D. (2013). *Loving with the brain in mind: Neurobiology and couple therapy.* New York: Norton.

Fishbane, M. D. (2019). Healing intergenerational wounds: An integrative relational-neurobiological approach. *Family Process, 58*(4), 796–818.

Fisher, H. (2004). *Why we love: The nature and chemistry of romantic love.* New York: Holt.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2005). *Affect regulation, mentalization, and the development of the self.* New York: Other Press.

Framo, J. (1981). The integration of marital therapy with sessions with family of origin. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 133–157). New York: Brunner/Mazel.

Friedlander, M. L., Heatherington, L., & Escudero, V. (2016). Research-based change mechanisms: Advances in process research. In T. L. Sexton & J. Lebow (Eds.), *Handbook of family therapy* (pp. 454–467). Oxfordshire, UK: Routledge/Taylor & Francis Group.

Friedman, M. (1965). Introductory essay. In M. Buber, *The knowledge of man.* New York: Harper & Row.

Gage, F. H. (2004). Structural plasticity of the adult brain. *Dialogues in Clinical Neuroscience, 6,* 135–141.

Gottman, J. (2011). *The science of trust: Emotional attunement for couples.* New York: Norton.

Gross, J. J. (Ed.). (2015). *Handbook of emotion regulation* (2nd ed.). New York: Guilford Press.

Hargrave, T. D., & Pfitzer, F. (2003). *The new contextual therapy: Guiding the power of give and take.* London: Brunner/Routledge.

Hatfield, E., Pillemer, J. T., O’Brien, M. U., Sprecher, S., & Le, Y. C. L. (2008). The endurance of love: Passionate and companionate love in newlywed and long-term marriages. *Interpersona, 2,* 35–64.

Imber-Black, E. (1993). *Secrets in families and family therapy.* New York: Norton.

Imber-Black, E., Roberts, J., & Whiting, R. A. (Eds.). (2003). *Rituals in families and family therapy* (rev. ed.). New York: Norton.

Jordan, J. (2010). *Relational–cultural therapy.* Washington, DC: American Psychological Association.

Lerner, H. (1985). *The dance of anger: A woman’s guide to changing the patterns of intimate relationships.* New York: HarperCollins.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2018). *Socioculturally attuned family therapy: Guidelines for equitable theory and practice.* Oxfordshire, UK: Routledge.

McGoldrick, M. (2016). *The genogram casebook: A clinical companion to genograms: Assessment and intervention.* New York: Norton.

McGoldrick, M., & Carter, B. (1999). Self in context: The individual life cycle in systemic perspective. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 27–46). Boston: Allyn & Bacon.

McGoldrick, M., & Carter, B. (2001). Advances in coaching: Family therapy with one person. *Journal of Marital and Family Therapy, 27,* 280–300.

McGoldrick, M., & Hardy, K. (Eds.). (2019). *Revisioning family therapy: Addressing diversity in clinical practice.* New York: Guilford Press.

McLaughlin, K. (2017, April). The long shadow of adverse childhood experiences. *Psychological Science Agenda.* www.apa.org/science/about/psa/2017/04/adverse-childhood.

Meaney, M. (2010). Epigenetics and the biological definition of gene × environment interactions. *Child Development, 81,* 41–79.

Rodrigues, S. M., Saslow, L. R., Garcia, N., Joh, O. P., & Keltner, D. (2009). Oxytocin receptor genetic variation relates to empathy and stress reactivity in humans. *Proceedings of the National Academy of Sciences, 106,* 21437–21441.

Rumi, J. (2004). The guest house. In C. Banks (Trans.), *Rumi: Selected poems* (p. 104). New York: Penguin.

Scheinkman, M., & Fishbane, M. D. (2004). The vulnerability cycle: Working with impasses in couple therapy. *Family Process, 43,* 279–299.

Siegel, D. J. (2015). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford Press.

Siegel, D. J., & Hartzell, M. (2003). *Parenting from the inside out.* New York: Penguin.

Spring, J. A. (2004). *How can I forgive you?: The courage to forgive, the freedom not to.* New York: HarperCollins.

Walsh, F. (2006). *Strengthening family resilience* (2nd ed.). New York: Guilford Press.

Walsh, F. (2010). *Spiritual resources in family therapy* (2nd ed.). New York: Guilford Press.

Walsh, F. (2016). Families in later life: Challenges, opportunities, and resilience. In M. McGoldrick, B. Carter, & N. Garcia-Preto (Eds.), *The expanding family life cycle: Individual, family, and social perspectives* (5th ed., pp. 339–359). London: Pearson.

Walsh, F., & McGoldrick, M. (Eds.). (2004). *Living beyond loss: Death in the family* (2nd ed.). New York: Norton.

Wile, D. (2002). Collaborative couple therapy. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 281–307). New York: Guilford Press.

Worthington, E. L., & Scherer, M. (2007). Forgiveness is an emotion-focused coping strategy that can reduce health risks and promote health resilience: Theory, review, and hypotheses. *Psychology and Health, 19,* 385–405.

Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. *World Psychiatry, 17,* 243–257.

POSTSTRUCTURAL APPROACHES

CHAPTER 10

Narrative Couple Therapy

Jill Freedman and Gene Combs

BACKGROUND

In therapy organized by the narrative metaphor (Freedman & Combs, 1996, 2002; White, 2007; White & Epston, 1990), we work to help people find new meaning in their lives by experiencing, telling, and circulating stories of as-yet-unstoried aspects of their lives and relationships. This work is more complex than a brief description of the narrative metaphor might suggest. In any given culture, some stories are much more widely circulated, believed, and acted on than others. We are born into the dominant stories of our local culture, and they shape our perceptions from that minute on. However, people do not usually think of the stories they are born into as stories. They think of them as "reality." Narrative therapists think of these realities as social constructions. In our current culture, we are undergoing a shift in what counts as a story of marriage. The "reality" used to be that marriage was reserved to formalize a union between a man and a woman. With cultural, political, and legal changes, same-sex couples can now story their relationships in a growing number of states and countries as legal marriages. Also, people in polyamorous relationships, people in relationships where one or more partners are nonbinary, and relationships including transgender or gender nonconforming people are all becoming more visible and recognized (Baumgartner, 2013).

Poststructuralism, especially as it is expressed in the late work of Michel Foucault (1977, 1985), has been an important influence on how narrative therapists work with the stories that circulate in our local cultures. Foucault showed how stories about what constitutes madness, for example, can marginalize certain people—separating those seen as mad from "polite society," and sequestering them in madhouses, where their voices cannot reverberate within the avenues of power.

Foucault used the word "discourses" to refer to the ongoing political/historical/institutional stories and practices that shape our ideas of what is true and what is possible. He argued that there is an inseparable link between knowledge and power. Because the discourses of a society determine which bits of knowledge are held to be true or proper in that society, those who most powerfully influence the discourse control knowledge. At the same time, the dominant knowledge of a given milieu determines who will be able to occupy its powerful positions. We see the discourses of power that Foucault studied as historical, cultural stories—grand narratives that have shaped (and been shaped by) the distribution of power in society.

As we are reminded by the continuing struggles against racism, economic inequities, and the many issues that intersect with them, society is not necessarily benign, fair, or just. Feminist critics of family therapy (e.g., Carter, Papp, Silverstein, & Walters, 1984; Goldner, 1985; Hare-Mustin, 1978; Laird, 1989) have shown us how, even when we try not to, we see certain possibilities as desirable and others are invisible to us.

Foucault was especially interested in how the "truth claims" carried in the "grand abstractions" of certain forms of empirical science can constitute a dehumanizing and objectifying discourse. He was interested in finding and circulating marginalized discourses—stories that exist but are not widely circulated or powerfully endorsed—that might undermine the excessive power of reductionistic scientific discourses. Foucault (1980, pp. 80–84) wrote of the "amazing efficacy of discontinuous, particular, and local criticism" in bringing about a "return of knowledge" or "an insurrection of subjugated knowledges."

Following Foucault (1980), we believe that even in the most marginalized and disempowered of lives, there is always lived experience that lies outside the dominant stories (Combs & Freedman, 2018). Narrative therapists have developed ways of thinking and working that bring forth the "discontinuous, particular, and local" (Foucault, 1980, p. 80) stories of couples and other social groups, so that they can inhabit and lay claim to possibilities for their lives that are outside the box of dominant narratives. This philosophical and ethical stance makes narrative therapy and narrative community work appealing to many people who are working to promote social justice (Audet & Paré, 2018; Combs & Freedman, 2012; Reynolds, 2019; see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim).

When we use the narrative metaphor and the lens of poststructuralism to orient our work as therapists, we cultivate an intense curiosity about each new couple we meet, cherishing each couple's unique stories. We work to invite partners to develop and live out narratives that they prefer around the particularities of their lives. This valuing of the meaning people make of their own experience over the meaning experts make of that experience has been referred to as the "interpretive turn" (Bruner, 1986). It leads us to decenter our meanings and to conduct ourselves not as experts but as interested collaborators—perhaps with an anthropological or biographical bent—who are skilled at asking questions to bring forth the knowledge and experience carried in the rich and complex stories of the couples with whom we work (Dickerson, 2013; White, 2011).

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

As narrative therapists, one of our principal intentions is to subvert the dominant practice in our society of measuring ourselves, our relationships, and others by standardized norms. For us, single-spectrum, binary scales (e.g., healthy–pathological, well-functioning–dysfunctional) invite therapists and the couples who consult with them into thin descriptions—pallid, reductionist accounts—of their multistoried lives. Binary normative scales pervade contemporary Western culture, and each of them coexists with a prescriptive story about the right or healthy or successful way to live or to have a relationship. None of us can measure up to the demands of all these norms. Norms focus our attention on whether our relationships are too rigid or too enmeshed, whether we are too focused on sex or not sexy enough, whether we are "soul mates" or have retained our independent identities. They focus our attention on whether our partners and ourselves are attractive enough, earn enough money, and so forth. Even when we do measure up to the dictates of a norm, it is within a thin, two-dimensional story.

This does not mean that we are opposed to health or that we approve of dysfunction; it just means that we are cautious about terminology, especially terminology that supports dominant norms. We ask those we work with to make ongoing assessments of the effects of our work. We want people to like the stories they are living out together. We want those stories to support meanings and actions that open perspectives of help and hope, and that minimize hate, harm, and inequities of power. Every relationship can be expressed and experienced through a great variety of narratives; many "true" stories may be told about any experience. We start from the stories based on experiences in couples' lives that are currently shaping a relationship and collaborate with couples to express and experience stories that suit them better.

Because we do not consider the partners in a couple to have essential, relatively fixed, core identities with predictable, stable characteristics, we do not look for fixed or predictable qualities such as "health" or "dysfunctionality" within them. Keeping in mind the interpretive turn, we ask the partners in each new couple we see to evaluate what is problematic and what is preferred in their relationship. We want to hear their stories of how the problems they name affect their lives and relationships. This does not mean that we think "anything goes." We are full participants in the process of therapy, and we inevitably bring our own opinions and lived experience along with us. For example, we are opposed to (among other things) abuse, coercion, and cruelty. When one of these problems appears to have invaded a relationship, we consider it our responsibility to ask questions that invite both partners to consider the ideas in the culture that support the problem, the effects of that problem on their own and each other's lives, and on their relationship, and to consider the stand they want to take in relation to it.

We strive to create an interactional space in which people can take responsibility for addressing and ameliorating the effects of problems. To us, this means that we must avoid lecturing or imposing rules. Instead, we want to invite partners to bring their "best selves" into a consideration of the problems that diminish their relationship and an exploration of how they might choose ways of living that diminish the effect of the problems on their relationship.

We work hard to think of problems as things and processes that are separate from the couples that they afflict. Rather than looking for pathology or flawed functioning within the relationship, we look for problematic discourses and offer couples the opportunity to describe and evaluate the effects of those discourses on their relationship. For example, Pat and Bill came to consult with our team about the impact that worries and fears were having not only in Pat's life but also in Pat and Bill's relationship (Cohen et al., 1998). In one conversation, Pat complained that Bill always walked ahead of her. At malls, he generally led them into the stores he wanted to shop in, not the ones she liked. When she noticed this pattern, Pat thought this meant that Bill did not care about her and her preferences. Bill thought all it meant was that he was a fast walker. As we asked questions to explore the cultural stories that shaped their way of walking, it seemed to the members of our therapy team that gender socialization had supported Bill in unthinkingly setting the pace and Pat in unthinkingly following along, even though it made her feel like a "little girl" or a "puppy dog." Thinking about the problem as gender socialization guided us in asking a series of small, nonaccusatory questions. We asked things such as where Bill had learned his fast style of walking, who his role models were, whether there were contexts in which he walked slowly, and what he thought about fast walkers in distinction to slow walkers. We asked Pat similar questions: What characterized the walk of a grown woman? What would she rather feel than like a puppy dog? Where had her mother walked in relation to her father? Our conversation allowed Pat and Bill to separate themselves from the problem, notice the effects it had on their lives, evaluate how it may have contributed to the worries that plagued Pat, and consider what they would prefer for their relationship.

Our desire was for Pat and Bill to have the last word as to what they preferred, and for their choices to be made within a multidimensional domain that positioned problems outside their relationship, where they could team up to face them.

THE PRACTICE OF NARRATIVE COUPLE THERAPY

The Structure of the Therapy Process

Although we take an active role in structuring the therapy, we ask couples to collaborate with us so that the process will fit their circumstances (Anderson, 2012).

Length, Frequency, and Number of Meetings

We negotiate the time of each next meeting as we go along, one interview at a time. At the end of each meeting, we ask whether the conversation has been useful. If it has, we ask how. This question puts those consulting us in the position of evaluating the therapy and keeps us from making assumptions about its effects. Then we ask whether the couple would like to meet again, and if so, when.

We want couples to be at least as active as we are in evaluating what schedule would be most useful. Sometimes, such as when partners are in the middle of intense conversations, they want to return very soon. More often, because they have been hearing each other in new ways and making new distinctions, they are interested in allowing time between interviews, so they can find out what difference these new experiences will make in their lives. We listen as they negotiate with each other about how long their explorations might take. If we have an opinion, we offer it—especially when the couple seems undecided—but we are careful not to impose it.

We generally meet with couples for 60 minutes at a time, but we have negotiated longer times when that would be useful and affordable. The time span and number of sessions is determined by each couple. Some couples come to consult about a single, clearly defined problem; therapy in such circumstances may require only a very few meetings. A few couples have so enjoyed developing rich, detailed stories of their lives together that their therapy has gone on for years, usually with meetings spaced at wide intervals. Most are somewhere in between.

Focusing on New Directions in Life

We try from the first to invite people to explore, describe, and experience new directions in life that are already unfolding—new distinctions, positions they have taken about their relationship to problems, and new stories. At the start of a first meeting with a couple, we ask whether it would be okay if we get to know them and their relationship in ways that have nothing to do with the problem before they describe what brought them to therapy. David Epston (1999) sometimes asks each partner to tell some "wonderfulness" about the other. This helps them and us keep the problem from coloring the entire description of them and their relationship. At times, we look back on the notes from this conversation for inspiration about contexts we might ask about. In later meetings, we often start by reading our notes from the previous session aloud and asking a question such as "Can you tell us about new developments that relate to what we were talking about last time?" Sometimes we begin by wondering whether there have been important thoughts or events that connect to possibilities identified in our previous conversation. Our intentions in reading the notes and in asking for continuing developments is to orient people to preferred stories that are developing rather than hearing an unfocused report of the week or a retelling of problem stories. Of course, we are open to hearing about anything that a member of a couple thinks is most important to speak of at a particular meeting.

We work to keep new understandings and preferred stories alive and growing between conversations. We use letters, documents, videos, and the like to document and circulate alternative stories. For example, after a therapy interview, we may write a letter posing questions that invite the partners to develop an alternative story even further than they did in the interview, or we may send a document noting the stands they have taken in regard to a problem.

The Role of the Therapist

David Epston (1999, pp. 141–142) writes:

> I chose to orient myself around the co-research metaphor both because of its beguiling familiarity and because it radically departed from conventional clinical practice. It brought together the very respectable notion of research with the rather odd idea of the co-production of knowledge by sufferers and therapist. . . . This has led, and continually leads, to practices to discover a "knowing" in such a fashion that all parties to it could make good use of it. Such knowledges are fiercely and unashamedly pragmatic.

We join Epston in thinking of our work as co-research. We engage with each new couple to observe, inquire into, and document the particulars of partners' situations in relation to their problems. With permission, we share insider knowledge from our previous research with other couples, and we ask them to evaluate the "fit" and the usefulness of that knowledge in relation to their problems. We take note of what works and what doesn't as we go along.

White (2000) describes a therapist's role in this work as decentered but influential. We participate, not as enforcers of professional knowledge, not as authorities on what constitutes a normal or healthy relationship, but as people with skills in facilitating a co-research project.

We ask questions to help expose gaps or contradictions in the problematic stories that bring couples to therapy, and to open space for and describe alternatives. We work to keep the conversation focused and relevant. We ask how the process is going and respond to people's answers. At times, we reflect on and summarize our understanding of what our co-research has developed, and we ask each partner in the couple what they would add, subtract, or describe differently.

We work to create a collaborative context. We situate our ideas in our own experience and try to make our intentions transparent. We recognize that as heterosexual, cisgendered, White therapists who are also economically and educationally privileged (Combs, 2018), we will make assumptions that do not fit for some of the people we see, and we will make mistakes with others. We strive to acknowledge this and to create a context in which everyone present feels free to speak about it. We encourage couples to ask questions about our questions and comments. Although we avoid "objective," "expert" assessments, we acknowledge that the role of therapist-interviewer is a powerful one. Each question we ask directs attention to a distinct domain and away from many others. We want people to make meaning of their own experience, but our questions inevitably shape the inquiry. For this reason, we "situate" our questions; that is, at times we describe where they come from and our intentions in asking them, so that people can evaluate our bias and decide how to relate to it. We believe that people are in a better position to interpret, make meaning of, and evaluate their own experience than outsiders are, even outsiders who are trained to help.

When we participate as co-researchers, we have more questions than answers. The following are some of the questions we (Freedman & Combs, 2000) have found useful to ask ourselves in keeping a co-researcher perspective:

- Whose voice is being privileged in this relationship? What is the effect of that on the relationship and on the process of therapy?
- Is anyone showing signs of being closed down, not able to fully enter into the work? If so, what power relations/discourses are contributing to the closing down?
- What are we doing to foster collaboration? Among whom? What is the effect of that collaboration?
- Is this relationship opening up or closing down the experience of "agency" (of being an active agent of change in one's own behalf)?
- Does this relationship take into account other relevant people, communities, and cultures? Are we considering how the ripples of this relationship affect other relationships?
- Are we asking whether and how the work is useful, and modifying it according to the answers we hear?

Assessment and Treatment Planning

In therapeutic conversations, we think about "generating experience" rather than "gathering information." In a rather literal way, we believe that we are making ourselves and each other up as we go along. This is a poststructuralist idea. We do not assume that a couple has a fixed interactional or relational structure that we can assess. We do not think of people or relationships as having stable, quantifiable identities or "typical" characteristics, so we do not try to discover or gather information about such characteristics. Instead, we think of people's lives as being multistoried, and we believe that each new telling of a story generates new possibilities for making meaning and taking action.

Instead of assessing, we are interested in hearing detailed, context-specific narratives. As we ask questions to bring forth their stories, we encourage couples to evaluate problems and their relationships to problems, as well as the therapy itself.

We ask questions that invite the partners in a couple to do these things:

- Evaluate their current situation.
- Name the problems involved.
- Evaluate their relationship to those problems.
- Take a stand regarding the problems.
- Tell and enact more satisfying stories of their relationship.
- Evaluate the usefulness of the alternative stories.

The stories we speak of emerge a little at a time, most often as snippets or details rather than as complete stories. Changing a detail can change the meaning of a whole story. We want to know whether the emerging stories speak to people of a more satisfying identity as a couple. In telling the new aspects of stories and reflecting on them, partners collaborate with us in an ongoing evaluation of their new expressions of themselves and their relationship.

Here are some questions we might ask in inviting people's evaluation of their situation and of their therapy experience:

"What name would you give the problem?"
"What is it like to experience the problem?"
"What effect does the problem have on your life?"
"What effect does the problem have on your relationship with each other?"
"What has it talked you into about your partner? What impact has that had?"
"What effect does the problem have on other relationships?"
"How does the problem alter your relationship with yourself?"
"Is this what you want for your relationship? Why or why not?"
"Is this what you want for yourself? Why or why not?"
"Are we talking about what you want to be talking about?"
"Is this conversation useful?"
"How is it useful?"

In telling and living out the newly developed strands of alternative stories, the partners in a couple evaluate many aspects of their lives: their private hopes and fears, their dyadic interactions, the contributions of each partner's culture of origin, their interrelationship with local institutions and traditions, and more.

Although we bend over backwards to avoid "expert," categorical, reductionist assessment, it would be misleading to imply that we make no assessments of any kind. One kind of assessment that we make has to do with which parts of a couple's story might be shaped by discourses that are invisible to the partners. We ask questions that invite people to notice and consider the operations of such discourses, and that offer them an opportunity to decide where they stand and how they would like their relationship to be in the face of such discourses.

We find it important to help couples distinguish and describe the effects of discourses that shape their relationship in two different ways: by setting the *power relations* in which they participate and by proposing *idealized images* by which they evaluate themselves and each other. This leads us to ask questions that invite them to consider the effects of discourses of gender, ethnicity, heterosexual dominance, class, corporate culture, patriarchy, age, or other sociocultural factors on their relationship. We work to make these conversations experience-near (using words and imagery that stay close to people's lived experience and avoid professional jargon). We try to have thoughtful, interactive conversations in which each question is responsive to the previous answer. It is difficult to capture the mood and tone of such inquiries in a series of hypothetical questions. We would not ask these questions in the beginning of a conversation. They would follow a detailed recounting of a specific experience. Typically, people respond to such questions with pauses, puzzling to express an answer. We think we may be on the right track when the initial response is, "I haven't thought about this before," followed by a pause. We might initiate such a conversation with questions similar to those that follow:

"Martha, you have just said that fear of humiliation keeps you from wanting to go to social events with Brian. You described his failure to introduce you to people he knows and his talking over you when you try to join in. Is that right?"

"Brian, what is it like to hear your actions being described that way? Does it fit with how you like to think of yourself?"

"Who do you think might have introduced you to this way of acting?"

"Your father and uncles undoubtedly did not make up this way of being. Where do you think they might have learned it?"

"Martha, I've noticed that all of these examples are of men. Do you think that this is a coincidence?"

"Do you think it is a way of acting only to women, or do you see it with children as well?

"What would you call this way of acting?"

"Brian, what do you think it might be like to be a woman or child who experiences this sort of discounting?"

"Is this what you would want women and children to experience from you? Why not? How would you rather have them experience you?"

"You have already said, Martha, that this discounting keeps you from wanting to socialize with Brian. Are there other ways it affects your relationship?"

"Is this what you want for your relationship? What would you prefer?"

"We've been talking about a strand of our culture in which women and children are invisible or are considered to be property. It is clear, Brian, that this does not fit with your thinking, although you have gotten pulled into some ways of acting that go with it. What name would you give to the ways of acting that you prefer?"

"Martha, do you think you've been pulled into some of the actions that go with these ideas as well?"

"What would you name them?"

"What has that been like for you?"

"What has it been like for the relationship, do you think? How would you prefer your relationship to be?"

Because we think that "self," "identity," "personhood," and the like are experiences that emerge and are always changing *in relationship*, we do not know exactly which "self" will be answering when we ask a person to draw a distinction or to evaluate the effect of an action. To make this transparent, we might ask, "Is that the problem speaking?" or "Whose values are guiding you in saying that—gay culture's or straight culture's or something else?"

In exposing discourses that create and maintain problems, couples can separate from the ways of being that are supported by those discourses, and identify and recognize preferred perceptions, attitudes, and actions. We are very interested to hear the stories of relationships and events that help people to have a sense of choice, agency, purpose, and accomplishment in their lives, both as individuals and as partners in a couple.

Goal Setting

While stories unfold and can go in multiple directions, a goal points in one particular direction. Our general purpose in therapy is to assist people in living out, moment by moment, choice by choice, life stories that make their worlds more satisfying. We are more interested in opening up possibilities than in closing them down. This makes us wary of "goal setting" as it is usually defined and practiced. The narrative metaphor biases us toward thinking about possibilities that unfold in living out a story, rather than about goals, which are usually set in advance and pursued single-mindedly. Instead of goals, we tend to speak of "projects" or "directions in life."

The process of identifying projects is fluid, shifting as new distinctions are made and as alternative stories unfold. Problems can be thought of as plots, and projects as counterplots. Just as partners in a couple may name different problems, they need not have the same project. They may name joint projects for the relationship, take up individual projects for themselves, or both.

Process and Technical Aspects of Couple Therapy

Listening

When we meet people for the first time, we want to understand the meaning of their stories for *them*. This means turning our backs on "expert" filters: not listening for chief complaints; not "gathering" the pertinent-to-us-as-experts bits of diagnostic information interspersed in their stories; not hearing their anecdotes as matrices within which resources are embedded; not listening for surface hints about what the core problem "really" is; and not comparing the selves that people portray in their stories to normative standards. We want to listen to their stories as stories, and we want to be attentive and responsive to their intended meaning in telling the story.

In the beginning, we ask about nonproblematic aspects of the life of each partner and of the relationship. We are interested in getting to know the members of a couple as people, and in making sure that the problem does not trick us into mistaking "them" for "it." Unless people insist on moving quickly into talking about problems, we spend a while listening to stories about their preferences and pleasures. At some point in this process, people do usually begin spontaneously to tell problem-tinged stories. If they don't, we can ask more directly about their problems.

As we listen to their stories, we try to put ourselves in people's shoes. We do not assume that we understand the meaning their experience holds for them. We listen and ask. We want to connect with their experience, so that we can understand the specific realities that shape, and are shaped by, their personal narratives. This sort of understanding requires that we listen with focused attention, patience, and curiosity while building a relationship of mutual respect and trust.

Deconstructive Listening

When we listen "deconstructively" to people's stories, our listening is guided by the belief that those stories have many possible meanings. The meaning that we as listeners make is inevitably different from the meaning that the speaker has intended. We seek to capitalize on this by valuing the gaps we notice in our understanding and asking people to fill in details, or by listening for ambiguities in meaning, then asking people about those ambiguities.

As people tell their stories, we look for opportunities to reflect our sense of what they are saying, and to ask whether the meaning we are making fits with their intended meaning. Even though we attempt to understand people's realities from something very close to their point of view, their realities begin to shift, at least a little, as they expand their narrative in response to our reflections and questions. Our very presence makes their world different. Throughout this process, we listen with thoughtfulness about what new constructions are emerging. We wonder aloud whether they are useful or desirable. In response to our request for details or clarification, a person might say, "I never thought of it that way." We would then want to know what difference it makes to think of it "that way." We strive to co-create a process in which people experience choice rather than "settled certainties" (Bruner, 1986) with regard to the realities that they inhabit.

Deconstructive Questioning

We believe it is our responsibility as therapists to cultivate an awareness of the dominant (and dominating) stories in our society, and to develop ways of collaboratively examining the effects of those stories when we sense them at work in the lives and relationships of the people who consult with us. This means that many of the questions we ask have a deconstructive intent. White (1991) defines "deconstruction" actively and politically:

> According to my rather loose definition, deconstruction has to do with procedures that subvert taken-for-granted realities and practices: those so-called "truths" that are split off from the con-

> ditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self and of relationship that are subjugating of person's lives. (p. 27)

The medical model and other discourses of modern power can lead people to a sense of themselves as "docile bodies" (Foucault, 1977), subject to knowledge and procedures in which they have no active voice. Subjugating stories of gender, race, class, age, sexual orientation, and religion (to name a few) are so prevalent and entrenched in our culture that we can get caught up in them without realizing it. Conversely, stories of potentially meaningful events can be drowned out or neglected just because they tell of life at the margins of society.

As Rachel Hare-Mustin (1994, p. 22) reminded us, "If the therapist and family are unaware of marginalized discourses, such as those associated with members of subordinate gender, race, and class groups, those discourses remain outside the mirrored room." As therapists, we must continually reflect on the discourses that shape our perceptions of what is possible, both for ourselves and for the people with whom we work. Such reflection puts us in the position to ask deconstructive questions—questions whose aim is to examine problems in detail and expose discourses that support them, as well as questions that might undermine those discourses.

Our language ("discourses," "deconstructive questions") can make this whole process sound heady and cumbersome. In practice, we strive to keep all that to ourselves. We ask small questions that invite people, one small step at a time, to reflect in their own language and metaphors on the taken-for-granted, unquestioned values, beliefs, and customs that shape their daily experience, and to evaluate whether those ways of living suit them. We strive to use their language as we proceed rather than expecting them to learn ours.

Externalizing Conversations

White (1988; see also Epston, 1993) has introduced the idea that the person is not the problem; the problem is the problem. The narrative practice of "externalizing" puts this idea into action. Just listening with the belief that problems are separate from people has a powerful deconstructive effect. It biases us to interact differently than we would if we saw people as intrinsically problematic. It creates a different receiving context for people's stories, one in which their stories almost always become less restrictive. As we listen to people's stories, we listen for the ways they refer to the problems in their lives. If we hear names such as "fear" or "blowing up," we orient to those things as entities or processes that are external to the people and acting on them in problematic ways. If we are not hearing names for problems, we might ask more directly for people to name them. We might say, "When you say that something comes between you in those moments, what would you call that something?" We contribute to the deconstruction of problem identities by objectifying problems. For example, if someone says, "My partner is mean," we might ask whether meanness colors their conversations.

We can locate problems in discourses by asking "externalizing questions" about contextual influences on the problem. What "feeds" the problem? What "starves" it? What does it promise? Who benefits from it? In what settings might the problematic attitude be useful? Which people would proudly advocate for the problem? What groups of people would be opposed to it and its intentions? Questions such as these invite people to consider how the entire context of their lives affects the problem and vice versa.

We have found it particularly helpful to say something like, "I don't think that you invented this way of thinking" to pave the way for people to keep discourses that support problems externalized and to contrast the effects of discourses to what they give value to in their lives.

As problems are externalized, it becomes established that rather than *being* the problem, the person or couple has a *relationship* with the problem. Members of a couple have the opportunity to describe their relationships with problems in a variety of ways. One consequence of an externalizing conversation is that it becomes clear that both partners have relationships with the problems they name.

In externalizing conversations, we are particularly interested to hear descriptions of the effects of problems. We ask about the effects of a problem on both members of a couple—on their lives and their relationships. This helps keep the identity of the problem separate from either partner. It mobilizes the members of the couple to join together in opposing the effects of the problem. This is particularly helpful when the problem has kept them apart. People can stop thinking about themselves or their relationships as inherently problematic, and instead can consider how they want to revise their relationships with problems.

Even though we are interested in the effects of problems on both members of a couple, we are not guided by ideas of reciprocity. Many discourses support power inequities in relationships. When these are exposed, although we are interested in the effects on both members of a couple, we work more with the member privileged by a discourse, as they have more responsibility to make changes and be accountable.

Naming the Problem and the Project

Naming a problem can open a way for examining it and thinking differently about it. The process of naming can be poetic and compelling. We recently saw a young mixed-gender couple. The man described the problem as waking him in the middle of the night with a gun to his head. When we asked him to name the problem (which he had called "anxiety attacks"), he named it "the thief" because it was trying to steal his sleep. His partner, who had been scornful of the fear and the difficulty in sleeping until this point, could easily relate to the terror of a burglary in the dark of night. She began to appreciate her partner's bravery in facing it alone. She suggested that he wake her so that she could help.

As we ask people to evaluate their relationship to problems, they often tell us what they would prefer in their lives in place of the problems. We listen for words in people's descriptions that might serve as good names for their preferred directions. We ask questions that invite them to identify the directions and name them as projects. These questions can be quite direct. For example, let us say a couple has named "blaming" as a problem, and that through answering our deconstructive questions, the partners have realized that they are living under the influence of the idea that each partner in a couple should intuitively "know" what the other wants. In answering still more questions, they have described how this idea feeds blaming and has each of them feeling that something is wrong with the relationship. In this conversation, they are recounting an incident in which they could have gotten caught up in blaming but did not. Julie tells how she finished a major project at work, let Fran know it was finally done, and described a way she would like to celebrate. Fran did not arrange the dinner Julie would have liked that night and did not even come home until late in the evening. In the past, "blaming" would have convinced Julie that Fran did not really care about the relationship. This time, Julie was able to escape "blaming," to ask Fran what went into her actions, and to believe Fran's answer. In such an instance, we might ask Julie whether asking about Fran's perspective instead of assuming she knew it reflected a preferred direction in life—one that blaming could have kept her from seeing. If Julie agreed, we could ask whether this direction represented a project in which the couple was interested. If the partners *were* interested, we could ask what name they would give the project.

Sometimes partners share the same problems and projects. Sometimes a problem and/or project concerns one partner but not the other. Even when partners do not describe or experience the same problems and projects, witnessing each other's stories, and hearing the problems and projects that shape them, can lead to new understandings and choices.

As people name problems and projects, we keep track of them. The explicit and direct discussion of projects and how they contrast with problems can be a vital part of therapy. Such discussion brings forth and thickens the counterplots to problematic stories. It heightens the meaning that is made of the experiences we "story" in therapy. Without an identified counterplot, experiences that lie outside the problem story may go unnoticed or seem trivial. With the aid of a counterplot, people can perceive shape and meaning in their nonproblematic experiences. For example, once the partners in a couple have agreed on "listening more with our hopes and less with our fears" as a shared project, any conversation they have can be plotted into the narrative of how hopes and fears influence their listening. Until such a project is explicitly discussed and agreed upon, conversations could be given many different meanings or no meaning at all.

We keep projects present in the therapy through short names or phrases such as "growing intimacy," "having a voice," or "standing against violence." We seek personal, evocative, and poetic names for problems and projects (Epston, 2000). These names often shift as the therapy progresses, and it is a therapist's job to keep up with the couple's changes in language and conceptualization. Throughout therapy, we ask questions that invite people to shape their perceptions, thoughts, feelings, and actions into stories according to the plots and counterplots they identify as meaningful for their lives.

Unique Outcomes

A "unique outcome" is any event that would not have been predicted by the plotline of a problematic story. It may be a plan, action, feeling, statement, desire, dream, thought, belief, ability, or commitment (Morgan, 2000). A unique outcome may be an exception to the problem, but unique outcomes can be identified at times, even though the problem is still operating. For example, a newly married couple consulted with us because Marla had discovered that Peter had not disclosed that he was deeply in debt until after their honeymoon. They named the problem distrust and we talked about the many ways that distrust had come between them. One of its effects was that although the couple had planned to have a child as soon as they could, the distrust had put this plan on hold. In the second meeting, Marla and Peter each said that the distrust was still in full force, but further conversation revealed that they had decided to go ahead and try to have a baby. This was a unique outcome that opened the conversation to a vision of a happy future, although distrust dominated the present. Unique outcomes constitute openings that, through questions and reflective discussion, can be developed into alternative stories.

Sometimes couples offer unique outcomes quite directly. For example, someone in describing a problem may say, "It's not always like that. Sometimes . . . " and go on to describe a unique outcome. It is not unusual, as therapy progresses and as members of a couple become involved in the reauthoring process, for them to save up new, unique outcomes to tell their therapist. At other times, unique outcomes are so buried in people's descriptions of their problematic stories that it is necessary to listen very carefully to hear them. For example, when one partner says, "It would have been okay if he hadn't . . . " and then proceeds to tell a problematic story, if we are listening closely, we can be curious about the "It would have been okay" part, just as we would be curious about the answers to direct unique-outcome questions.

Sometimes we might notice events that, given the problematic story, we would not have predicted: Partners who believe they have communication difficulties may eloquently and clearly describe a problem in a way that suits them both, or one partner may show up on time to meet the other for therapy, even though the problematic story is one of irresponsibility.

Most often, as we listen deconstructively and ask couples about the effects of problems on their lives and relationships, we begin to get glimpses of events that lie outside the problem story. If we do not hear of actions that speak of non-problematic intentions, commitments, or values, we inquire more directly about their existence. When we are working with an externalized problem, a straightforward way of looking for a unique outcome is to ask about the influence of one or both partners on the life of the problem; that is, we ask questions such as "Has there ever been a time when [the problem] tried to get the upper hand, but you were able to resist its influence?" or "Have you ever been able to escape [the problem] for even a few minutes?" or "Is this problem *always* with you?" When questions of this sort follow a detailed inquiry into the effects of the problem on the person or couple, people can almost always tell us the story of a time they were able to avoid the problem's influence.

The Absent but Implicit

Michael White (2000) describes how it can be useful to listen for purposes, values, hopes, commitments, and the like, that are "absent but implicit" in people's narratives. He draws on the writings of Bateson (1980) and Derrida (1978), which illustrate how we draw distinctions by contrasting one experience with another. No experience has a set meaning that exists independently of other experiences. We make meaning through operations in which we say (or think, or sense), "This is different from . . . " If we listen closely, using what White has called "double listening," we can hear implications of the background from which our present experience differs. These "implied" background experiences are rich sources of alternative stories (Carey, Walther, & Russell, 2009; Freedman, 2012). For example, if a person has the foreground experience of frustration, the individual must have background purposes, values, or beliefs that are not being attained. If a person experiences despair, the individual must have hopes, dreams, or visions of the future that seem unlikely to be fulfilled. If a person experiences injustice, the individual must have a conception of a just world (White, 2003). To begin a conversation about the absent but implicit, we don't simply work to discover the opposite of a problem. Instead, we assume that there is a contrasting experience that may not be obvious but is one about which we can ask. It follows that if a person is speaking at length of frustration, we can ask questions that invite the individual to notice the purposes, values, and beliefs that are being frustrated, and so on. When we hear problematic stories, we listen for these sorts of implications.

For example, Gregory and Tom had been in a relationship that they described as very conflictual for about a year. They came to therapy to decide whether to stay together. In an early therapy conversation, Gregory asserted that Tom should quit his job as a chemical dependency counselor. Gregory described the difficult work demands, long hours, and low pay, and repeatedly said, "I think he should quit." Tom looked quite distressed as he talked about the importance of the work he did and the contempt that Gregory held for it.

Thinking about the absent but implicit and double listening, we wondered what kind of experience Gregory might have been contrasting with his experience of Tom's job. We asked, "Why is this important to say in front of Tom?"

Gregory was surprised that his answer was not obvious. "I just want him to be happy," he said. "When he is away from all the pressure of work and those crazy people—when we're away on vacation or even have a long weekend—he's happy. I just want that. When he's happy, there is not so much fighting."

Tom had heard Gregory's request that he quit his job many times. He had taken it not as a plea for his happiness but as an assault on his identity. He was astounded to hear what was absent but implicit in Gregory's suggestion that he quit his job.

This turn in the conversation created a way to begin to explore what happiness meant to both Tom and Gregory, and to hear stories of their experiencing it as a couple. These stories changed the tone of the conversation and offered hope. We had a new platform from which to hear preferred stories and consider problems, as well as an expanded understanding of what might be possible and preferred in the relationship.

Developing Stories from Unique Outcomes and the Absent but Implicit

When we find a possible unique outcome that seems relevant and interesting to one or both partners, we ask questions that invite the couple to develop it into an alternative story. We do not have a formula to follow in this process, but we do keep in mind that stories involve events organized by plot through time in specific settings, and that they usually include more than one person. A big part of the reason new stories make a difference in people's lives is that a performance of meaning occurs when they tell them to other people. As people tell their stories, others who are present witness them. The telling, witnessing, and retelling within the space of therapy make up a ritual of sorts—one in which new meanings can be enacted, discussed, and brought into being. We facilitate this process by asking questions to develop an experientially vivid story that is rich in detail (Freedman & Combs, 1993).

White (White & Epston, 1990), following Bruner (1986), speaks of the "dual landscapes" of *action* and *consciousness* (or, in his more recent work, *identity*). He suggests that the stories constituting people's lives unfold in both those landscapes, and that it can be helpful for therapists to inquire about both. Let us look first at the landscape of action.

The landscape of action includes *detail* in *multiple modalities* involving *multiple characters* or viewpoints in a specific *scene* or *setting*. It also includes the action itself. What happened, in what sequence, involving which characters?

Taking the very simple example of Jack and Lisa, who at an initial therapy appointment say that their relationship has been deteriorating for years and that this is the first time they have sought out therapy, we might wonder whether simply deciding and following through in coming to therapy is a unique outcome. The following are some questions we might ask:

"Who actually made the suggestion that you come to therapy?"
"What was the look on Jack's face when you suggested it? Did the look change as you talked more?"
"Jack, what did you think when Lisa first made the suggestion? How did that change for you as you talked?"
"Were there conversations or interactions between the two of you that prompted you to bring this up, Lisa? Was there something Jack said?"
"Jack, do you remember that? What were you thinking that got you to say that?"
"Who would be most pleased that you have taken this step? What would they say about it?"

In the landscape of action, we are interested in bringing forth each person's "agentive self"; that is, we ask questions with an eye toward enhancing those aspects of the emerging story that support "personal agency" (Adams-Westcott, Dafforn, & Sterne, 1993). The very act of reauthoring requires and demonstrates personal agency, and most people experience that in this work. One way we make personal agency apparent is by asking, in a variety of ways, how people have accomplished what they have. In the preceding example, we might ask the following questions for this purpose:

"Given the hopelessness you described, Lisa, what did you draw on in deciding to do something in the face of it?"

"Were you preparing somehow to take this step? What went into that preparation?"

"Jack, do you think that Lisa knew that you would be willing to come? How did you get past the hopelessness to agree on doing something so foreign?"

We think about the *shape* of a story as it comes forth: What happened before the unique outcome? How smoothly did things unfold? Were there false starts involved? To what did this incident lead? In this regard, we are especially interested to know whether there is a turning point—a place where the story changes to a preferred direction. Although "turning point" is not a fitting metaphor for everyone in every situation, when it does fit, it distinguishes a significant event that we can plot in time. We believe it is useful to focus special attention on this sort of event, bringing forth even more shape and detail, perhaps even treating it as a story within a story.

No matter how vivid a story is in the landscape of action, if it is to have *meaning*, it must also be developed in the landscape of identity. By "the landscape of identity," we refer to that imaginary territory in which people plot the meanings, desires, intentions, beliefs, commitments, motivations, values, and the like that relate to their experience in the landscape of action. In other words, in the landscape of identity, people reflect on the implications of experiences storied in the landscape of action.

To explore the landscape of identity, we (Freedman & Combs, 1993) ask "meaning questions," which are questions that invite people to step back from the landscape of action and reflect on the wishes, motivations, values, beliefs, learning, implications, and so forth, that lead to and flow from the actions they have recounted. For example, we may ask:

"What do you think it says about your relationship that you agreed to come together to therapy?"

"Does it characterize the way the two of you do things to have secret hope in the face of hopelessness?"

In coauthoring stories, we move between the landscape of action and the landscape of identity, weaving the two back and forth, again and again.

Unique outcomes are usually expressed as events, so we respond to them first with questions in the landscape of action, then with questions in the landscape of identity. The absent but implicit usually has to do with something someone gives value to that is not being directly expressed, so we begin our inquiry in the landscape of identity. This can be particularly helpful in therapy with a couple whose relationship is characterized by conflict because it changes the tone of therapy, for example, from anger to appreciation (Freedman, 2012).

With one couple, in an early exploration of the problem, Michelle complained bitterly about Ron's preoccupation with a book he was writing. She said that she was relegated to the job of cook and maid in their relationship as he spent most of his time in his study researching. When we said, "We are getting the idea that you might be missing something, is that right?" Michelle muttered, "Yeah, I guess." When we persisted in asking if she were perhaps protesting something or hoping for something in speaking of this, she said, "There was a closeness that was special in our relationship that I think we are losing. Ron calls me unsupportive. I feel ignored. What happened to the closeness?" With this answer we had an invitation to explore the landscape of identity and hear about the importance of closeness for Michelle and the difference it has made in her life. Since we had a sense from Ron's nonverbal responses that this was important to him as well, we invited him also to answer questions in the landscape of identity about the meaning and contribution of closeness to their relationship. Then we asked questions in the landscape of action to hear experiences that Michelle and Ron have had as a couple and separately that had to do with closeness.

When we are able to use the absent but implicit to move into a conversation about values that members of a couple share, it often results in hopefulness and a resolve to enact these values in their relationship. If, even after these kinds of conversations and commitments, members of a couple are recaptured by a problem, we have found that it often has to do with the pull of discourses. When this happens, we have found that members of a couple are often receptive to deconstructing conversations. They have felt the pull of the discourse in ways that interfere with what they give value to, so questions about the working of the discourse and ways of responding to it are welcome.

For example, after Michelle and Ron enacted their rediscovered closeness for several weeks, Michelle found herself once again spending evenings alone in the kitchen as Ron engaged with the computer in his study. We asked questions to expose the pressure Ron felt at work and his worries that if he didn't publish more, he would not be awarded tenure, forcing the couple to move again. As we talked about this, we discovered that it was not just the worries that Ron had about work that were disturbing him. He also experienced pressure to be a better partner and anger at Michelle's lack of understanding.

As Michelle witnessed what Ron said, she understood Ron's hours in his study in a different way. Near the end of our conversation, they were talking about ways of escaping both the ideas of success from the academy and the limited ideas of closeness that come from overfocusing on the quantity of time a couple spends focused only on each other. They considered ways of expressing closeness that include joint decisions about professional choices and each partner supporting the activities that are meaningful for the other.

Time: Developing a "History of the Present" and Extending the Story into the Future

Once we have identified a preferred event and developed a bit of its story and meanings, we want to link that event to other preferred events across time, so that their meanings survive and the events and their meanings can thicken a person's or couple's narrative in preferred ways. Therefore, once a preferred event is identified and storied, we ask questions to link it to other past events, and to develop the story of those events. Here are some examples of questions that might identify such events:

"When you think back, what events that you might be building on reflect other times when you could have been pulled apart, but that you came together as a couple?"

"If we were to interview friends who have known you throughout your relationship, who might have predicted that the two of you would have been able to accomplish this? What memories might they share with us that would have led them to predict this?"

We can also ask how the emerging new story influences a person's ideas about the future. As partners free more and more of their past from the grip of problem-dominated stories, they are able to envision, expect, and plan toward futures they like better for their relationship. We might ask:

"We have just been talking about an accomplishment and several events in the past that paved the way for this accomplishment. If you think of these events as creating a kind of direction in your lives, what do you think will be the next step?"

"You have learned some things about each other that have changed your view of each other and of the relationship. If you keep this new view in your hearts, how do you think the future might be different?"

Witnessing and Positioning

Often members of a couple expect a therapist to act as a judge or teacher, and hope that the therapist will align with them or lead them to act differently. Instead, we hope to engage people in the telling and retelling of preferred stories. As one partner speaks, we want to help the other to listen and reflect. We hope that in witnessing each other's stories, partners will not only arrive at new understandings but also contribute to each other's stories. We believe that when both members are immersed in preferred stories, their difficulties will look different.

There is a rhythmic alternation between telling a story and witnessing it that characterizes narrative work. We set up a structure early in our work with couples that runs through most of our subsequent conversations (Freedman, 2014). We ask one member of the relationship to tell their story, while the other listens from a witnessing position. Once a story has been told, we ask the partner in the witnessing position to reflect on what was heard. We then turn back to the teller of the original story and invite the person to reflect on the partner's reflections. After the teller reflects on the reflections, we invite the partner who was originally in the witnessing position to now relate a story from their own experience.

We initiate this process by making eye contact and speaking primarily with one person, referring to the other in the third person and, by implication, suggesting that the other comment only after we have had enough conversation to bring forth and develop a meaningful bit of story with the first person. Sometimes we need to be more explicit, saying something like "What I would like to do is speak with you, Ruben, for a while, as you, Sarah, listen. After a bit, I'll turn to you, Sarah, and ask what thoughts you have been having as you listened to Ruben. Then we'll switch and you, Ruben, will be in the listening position while Sarah and I have a conversation. Would that be okay?"

When we ask one partner to witness the other's story, we hope that the witness will hear something new. We find that at times it is important to be thoughtful about the attitude or position of the witnessing person (White, 2004). For example, with a certain person, we might say, "Would you be willing, as I talk with Vernon, to listen as you would to a friend? With friends, sometimes you can suspend your own point of view and listen just to understand. Would that be all right?"

With another person, or at a different point in the therapy, we might choose very different language. We might say, "Remember how you listened when Vernon was describing the poem your daughter wrote? Do you think you could listen that way as he talks now?" We want to assist people in listening from a vantage point in which they can hear things that are new and worthy of appreciation in their partner's stories. Especially in the beginning of therapy, when the influence of entrenched problems is strong, this takes great care. It helps to know a variety of positions from which to invite people to listen. The following list is not exhaustive, but we hope it illustrates some of the positions for witnessing that we have found useful:

- Ask the person to imagine a chosen person or team of people by their side, who will help to create and maintain a position of security (or calm, or curiosity—whatever might be a useful attitude).
- Ask the person to identify a context (meditation class, watching their child perform, listening to an inspirational speaker, coaching a valued student) in which they use skills, abilities, or perceptions that might be helpful in this context. Invite the person to listen from within that imagined context.
- Use the vantage point of a version of self that is attending to "what is important" rather than "being right." Begin by talking with the witness about hopes, values, and wishes for the relationship. Invite the witness to hold these close as they listen to what the partner is saying.
- Listen the way a friend, mentor, or role model might listen.
- Listen from the vantage point of "the relationship."
- Together, construct an anti-anger (or anti-hurt, or anti-pessimism, etc.) position. Do this by inviting the person to tell stories that illustrate that anti-anger position. Ask enough questions to assist the person in becoming experientially involved in the anti-anger position and naming the skills and practices involved in that position. Then ask the person to witness from that place.
- If there is one in the therapy setting, use the one-way mirror. Have one partner go behind the mirror to physically create a space for appreciative, reflective listening as you interview their partner on the other side.
- Use video recording or live, closed-circuit video, so that the partner watches the video from a separate location. This can be especially useful when conflict is so pronounced that it prevents partners from having the space to speak.

After the first partner has told a bit of story and the other has listened from an appropriate position, we invite the witnessing partner to give voice to what they have witnessed. We might ask general questions, such as "What was it like to hear what Brad was saying?" or "What thoughts were you having while Linda was talking?" However, we often find it useful to ask questions that rather than leaving the field for response wide open, more specifically invite people to respond to unique outcomes and preferred directions:

"Were you surprised when Raoul described you as taking the time to let others know you care?"

"What did it mean to you to hear Chantal say how important the relationship is to her?"

"When Jason was describing your daughter's birthday party, you were beaming. Can you tell us some of what you were feeling as you listened to that?"

We then make space for the original teller to respond to the partner's reflections, asking story development questions as they seem appropriate. We use this format to facilitate not only witnessing of each partner's versions of events but also deconstruction of problematic meanings ascribed to those events.

Relational Identity

In therapy, when partners begin describing problems in therapy, it is not unusual for each to describe the problem as if it were part of the other's identity, and to give it a very stable description, such as "He is a cold and judgmental person." This kind of description, and the perception on which it is based, fosters blame, regret, resentment, and hopelessness. If we can resist the influence of discourses that support essential identities and think instead about identities as being multistoried and fluid, we are much freer to notice different experiences of our partners, our relationships, and ourselves, and to notice what contributes to those differences.

We treat identity as a project (Combs & Freedman, 2016; Weingarten, 2013). This is different from the discourses of popular psychology, which more often talk about finding one's "true self" as if it were a preexisting treasure just waiting to be dug up. Those discourses invite us to categorize ourselves on the basis of 10-point checklists. They focus more on who we *are* than on who we are *becoming*, and on who we are as individuals rather than as participants in various collectivities. It takes vigilance and the support of others to resist these discourses and approach identity as a project that we undertake in interaction with others.

We have previously described (Freedman & Combs, 2004) a man who had this to say about his marriage that had just ended: "I don't know what happened. I married my baseball card and it still didn't work out! What more could I have done?" When we asked what he meant by his "baseball card," he said, "You know. Baseball card. It's got a picture and a list of facts about the player. I married my baseball card. She looked perfect, her stats were perfect, but somehow we never had anything to say to each other." Perhaps this is an extreme example, but it illustrates how we conspire together to treat each other as fixed commodities. In narrative therapy, we look for ways to deconstruct this kind of characterization and invite people to consider how together they can help each other enact new ways of being—new, relational, identities that partake of new possibilities.

Thinking about identity as something that develops in relationship has led us to wonder aloud with people what difference it would make if, instead of asking, "Does my partner have these qualities?" they asked, "Is there room in the relationship to become the person I want to be?" or "Am I liking myself better as I spend more time with my partner?"

These have been very useful questions. In answering them, people often recognize that although they may be with someone who has all the "qualities" they are looking for, they do not much like themselves when they are with that person. We have also worked with couples for whom the change of focus from "Does this person measure up to who I think my partner should be?" to "Who do I get to be when I am with this person, and do I like myself?" has produced joyous results that are wonderful to behold. This shift in focus often helps people let go of the idea of changing their partners and work instead on building ways to witness and appreciate each other, and to focus on and witness the relationship that they are creating.

Outsider Witness Groups

Besides one partner reflecting on the other's story, at times the therapist may reflect or may include an outsider witness group. The term "outsider witness" comes from the writings of anthropologist Barbara Myerhoff (1986), who worked with a group of elderly Jews who had been displaced from their Eastern European origins and were now living rather marginalized lives in California. Speaking of a set of murals they painted in a community center, and a parade they organized to show valued aspects of their lives to the larger community, she said, "By enacting their dreams publicly they have altered the world in which they live. . . . Skillfully the old Jews have managed to convey their statement to outsiders, to witnesses who then amplified and accredited their claims" (p. 284). The outsider witness groups of narrative therapy serve an analogous function: They create a setting where people can tell their preferred stories to a group of outsiders, who then amplify and accredit the stories they witness.

At times, particularly as part of training or consultation, outsider witness groups are composed of therapists. At other times, in response to our raising the possibility, couples agree to our inviting another couple (whose members have insider experience in dealing with a problem similar to theirs) to serve as an outsider witness group. Or the partners may invite other people who are important in their lives to join in as outsider witnesses.

For example, if we are working with a couple struggling with infertility, with the couple's permission, we might ask other couples that have been through infertility struggles to join the group. When we have an outsider witness group, we structure the session in a very particular way that includes four parts (Cohen et al., 1998; White, 1995, 2005).

In the first part, the therapist interviews the couple while the outsider witness group observes from behind a one-way mirror (or at a bit of a distance). In the second part, the group switches places with the couple and the therapist. The couple and therapist listen as members of the group have a conversation, raising questions and commenting about what they have watched.

In this second part of the interview, the outsider witness group members have a conversation, keeping the focus on what stood out for them, what images of the partners' lives and identities were evoked by what stood out, how that resonated with their own experience, and where they were transported by the interview (White, 2005). We ask team members to situate their reflections in their own experience, to acknowledge the trust the partners have shown in opening their lives to the presence of others, and to comment on the difference that being part of the conversation makes to their own lives.

In the third part, the couple and therapist switch back to their original places, and the couple responds to the reflections as the group observes. In the fourth part, everyone meets together to deconstruct and reflect on the purposes of the interview. The therapist and outsider witness group members respond to questions about their purposes, their questions, and the directions they pursued in the interview.

Documenting and Circulating New Stories

We are interested in documenting and circulating the new stories that emerge in therapy, to thicken them and keep them alive (Fox, 2003; White & Epston, 1990). We take notes in therapy to document new stories as they develop. We often refer back to these notes and read them aloud. When the members of a couple take stands or achieve new things, or reach turning points, we might create a document or certificate together that formalizes this newly distinguished event in their story. We often make videos for their personal use in which couples reflect on how far they have come. We may create videos or documents about what they have learned that, with their permission, can be viewed or read by others facing similar problems (White & Epston, 1990). Through this kind of exchange, couples can band together with others in virtual leagues.

We sometimes write letters between therapy meetings. In these letters, we reflect on unique outcomes and ask questions that we did not ask in the therapy conversation. Our intention in such writing is to thicken and extend the knowledge that has begun to emerge there. We sometimes generate formal documents that list important elements of new narratives (Freedman & Combs, 1997). To encourage the circulation of this knowledge, we may invite couples to share these documents with other people in their lives.

MECHANISMS OF CHANGE

We think that people's experience of the meaning of their lives and relationships changes through changes in their life narratives. We approach all therapy as an experiential process through which people claim, live out, and make meaning of stories that add new substance and new possibilities to their lives. In our work with couples, therapy is also a process in which partners witness each other fleshing out and giving new meaning to each other's stories. The mechanism of change in narrative therapy is the telling, retelling, witnessing, and living out of multistoried, "thickly described" lives.

When couples come to therapy, their accounts of their relationships are generally problematic and limited. This has to do, at least in part, with larger cultural stories or discourses that support particular sets of stories and meanings and not others. As people's narratives change, what they do and perceive changes as well. We facilitate the process of change by asking questions to highlight unstoried events and to encourage meaning making around those previously unstoried events; then, we tie the meaning to memorable actions and contexts.

Another way to describe our ideas about change is to say that in successful therapy, new meanings are performed. "Performance of meaning" is a concept that narrative therapists have borrowed from poststructural anthropology—particularly from the work of Myerhoff (1986), who gave numerous examples of how, instead of being an innate quality, meaning arises through performance. Unless a story is told and retold (circulated, written down, acted out, sung, etc.), it may have no lasting meaning. In the light of this notion, the new strands of story that emerge in response to our questions should be circulated and put into action to ensure that they become meaningful. We believe that change occurs through experience of the performed meaning that takes place in waves of telling and retelling.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

The narrative approach has general applicability. Although the length, intensity, and specific outcome vary from problem to problem, from person to person, and from context to context, the approach is as effective for couples seeking premarital counseling as it is for couples struggling to reclaim their relationship from violence and abuse, or for couples in which one or both partners have been diagnosed with a serious mental illness.

That said, our experience is that some couples prefer a different kind of therapy relationship than what we offer. Some people are seeking instruction or expert advice. Others are more interested in exploring their histories to find out why they are in their current situation. Some couples say they want cognitive-behavioral therapy because they have read that it is evidence-based. We regularly ask people how the therapy is going for them, and we are open and willing to refer couples if they are seeking a different kind of therapy relationship.

We find that most couples coming to therapy are concerned with whether their relationships improve, not how the therapy relationship is structured. Because popular notions of therapy include descriptions such as "getting to the root of the problem" or "improving communication skills," they may initially use words that seem to indicate a preference for a different kind of therapy relationship. With further conversation, we have found that most couples are simply using the language available to them to express their interest in improving their relationships, and we find narrative therapy very useful and effective for that purpose.

The skills and values we have cultivated to become good narrative therapists make it difficult for us to stand outside our work and assess it by conventional empirical criteria. For us, the most important aspect of narrative therapy is the worldview. We do not think of people in terms of the traditional, expert, individual diagnoses that underpin most "evidence-based" research. We do not believe that we possess universalizable, one-size-fits-all, expert knowledge about what would be most helpful to each new couple we meet. As we discuss in more detail at the beginning of this chapter, the narrative worldview is based in poststructuralism, which is skeptical of the positivist/empiricist project that supports current trends toward using population-based statistics to prescribe what must happen in therapy with unique people in their unique contexts. Narrative therapists focus on the insider knowledge that people have acquired in their local, experience-near worlds. As Duvall and Béres (2011) say, narrative therapists favor "practice-based evidence" over evidence-based practice. Our most common form of research is "co-research" (Epston, 1999), in which we ask the people we are sitting with in an ongoing way whether the therapy is helpful, and what in particular is helpful about it. The documentation, compilation, and circulation of the knowledge that comes forth through co-research builds up a body of insider knowledge that constitutes the main evidence base for our work as it continues to evolve (see Maisel, Epston, & Borden, 2004, for a vivid illustration of the existence and usefulness of large archives of insider knowledge).

Researchers who are interested in narrative approaches tend to do qualitative rather than quantitative studies. We could find no randomized controlled trials of narrative therapy in our search of the literature. None of the published qualitative studies of narrative therapy that we could find (Besa, 1994; Etchison & Kleist, 2000; France & Uhlin, 2006; Kogan & Gale, 1997; O'Connor, Davis, Meakes, Pickering, & Schuman, 2004; Seltzer & Seltzer, 2004) directly address couple therapy, but the studies are all supportive of narrative therapy as an effective treatment modality in which clients improve and therapists do what they say they do.

Carey (2007) summarizes the psychological research concerning narrative and the formation of identity and meaning. In a concluding paragraph, he says, "Taken together, these findings suggest a kind of give and take between life stories and individual memories, between the larger screenplay and the individual scenes. The way people replay and recast memories, day by day, deepens and reshapes their larger life story. And as it evolves, that larger story in turn colors the interpretation of the scenes."

CASE ILLUSTRATION

ln Ellen's initial phone call, she told me (JF) that she and Mitchell had been married for 2 years and that they were interested in coming to therapy to work on their relationship.

When we met, I began by asking them to tell me what they appreciated about each other. Ellen talked about Mitchell's sense of humor, honesty and integrity, and strong work ethic. She told me about the business he had created, helping people and companies with computer issues, and how it was thriving. Mitchell talked about Ellen's gentleness, kindness, and intelligence. He told a story about watching her tirelessly playing with her niece. He told me that she worked as the business manager of a consulting firm. They filled in their ages (Ellen, 30, Mitchell, 34) and noted that neither of them had been married before.

Next, I asked if either Mitchell or Ellen had questions for me. I hoped in asking this to begin to establish the therapy relationship as a two-way, collaborative one. They declined to ask anything but noted my invitation to ask as we went along.

Then I asked if it was okay to talk about the problem. The first thing that they told me was that they had an unsolvable problem. In the 2 years that they had been married, they had consulted—as a couple and individually—with many therapists. They also had gone to two marriage encounters and had consulted several physicians. Mitchell had attended a men's group. They were now trying again with me.

The problem, as they described it, was a devastating difference about sex. Mitchell said that he found sex distasteful, a big nothing. Ellen liked sex and saw it as part of intimacy. She began to quietly weep as she said that she didn't want a marriage without sex and didn't want sex with someone outside of the marriage.

Sex therapists had suggested massage without expectation of intercourse. A sexual surrogate had helped facilitate some feelings that could be described as sexual, according to Mitchell, who grimaced as he said this, and then a couple therapist suggested that Mitchell be in charge of all initiation—with the result that there wasn't any from that point on. That suggestion had been given 10 months before the couple came to see me. Ellen said that this therapist's suggestion was the worst thing that had ever happened to them. Mitchell said it helped him make a decision that he was through. No more working on sex.

They had engaged in what Mitchell described as "mechanical sex" about once a week with the help of Viagra for a few months before their marriage. For Ellen, this time led to glimmers of hope about a satisfying future. Mitchell compared it to a "psychic root canal." These "mechanical" experiences led him to a sense of despair and hopelessness.

I was interested in helping Ellen and Mitchell find an experience-near name for the problem or separate names, if that seemed more fitting. Often, in couple therapy, I am interested in drawing each partner out about their experience of the problem, with the other partner witnessing, perhaps to understand. I began this witnessing process with Ellen and Mitchell but with their comments that they had heard all this before in their many attempts to get help for their difficulties and Mitchell's insistence that he was through working on sex, I decided to see if I could facilitate their finding a shared problem name on which both agreed. We considered "differences in sexual desire" and "hurt feelings" before settling on "hopelessness." We made the following document that summarized the effects on Ellen and Mitchell of hopelessness and their stand on these effects:

Ellen and Mitchell's Position on Hopelessness

1. Hopelessness has taken over the mood of the relationship, making everything gloomy. This is not what Ellen and Mitchell want. Early in their relationship they experienced fun and joy, and they want that back.
2. Hopelessness taunts Ellen and Mitchell about their relationship. At times, it convinces Ellen that their marriage is fraudulent. This is not good because it keeps Ellen from planning about the future or sharing stories about her relationship with others. This in turn has Ellen isolated and trapped in an unhappy present. She would like to feel more positive and connected to others.
3. Hopelessness has Mitchell thinking that he should never have gotten married. This is not what he wants for himself because he would like to feel like a legitimate partner with something to offer.
4. Hopelessness is creating a gulf between Ellen and Mitchell. It creates a fear of misunderstanding moments of closeness they do experience. The reason they are together has to do with the closeness they felt in the past, and they would like to enjoy this again.
5. Hopelessness obscures all of the good things about their relationship. This only makes the problem worse, and they would like to be able to hold on to the good things.
6. Hopelessness has made Ellen believe that she is not desirable. This is not good because it takes some of Ellen's confidence away.

Ellen and Mitchell hereby agree to work to keep hopelessness out of the picture. Instead, they would like to feel good about the future, feel connected to others, feel confident and legitimate, and regain closeness, fun and joy.

Both Ellen and Mitchell agreed that this process seemed like a helpful step against hopelessness, and they looked forward to continuing.

I began our second meeting with a reading of the document, with space for corrections or additions, then, wondering where our first conversation had taken them and how they had engaged in some of the determinations they made to keep hopelessness at bay. In both this conversation and the next, Ellen and Mitchell each related experiences they had had of enjoyment, fun, and getting together with others. They said that they realized in our first conversation that one of the effects of hopelessness was that it had kept them from socializing with friends. They felt like they could do something about this that would help them feel legitimate as a couple; consequently, they had invited friends to get together with them. I asked many questions to develop rich conversations in which each of them told detailed stories—that the other witnessed—of enjoyment, fun, and getting together with others. As part of these, I asked them what they appreciated about each other, about themselves, and about the relationship.

When I went to meet Ellen and Mitchell in the waiting room for the fourth meeting, I noticed that both of them were occupied with their phones, facing away from each other. They accompanied me to my therapy space silently, in single file.

As is usual for me, I began our meeting by reading the notes, then asked how they had continued some of the themes we talked about the time before. My purpose in doing this is to invite people to engage in preferred stories that are developing rather than reporting the events of the time since we met, which seems to be the idea many people have about what to do in therapy.

This time, my reading was met with silence. Eventually, Mitchell began speaking about how things had not gone well. Ellen interrupted and disagreed. I asked Ellen if it would be okay if I spoke with Mitchell while she listened, simply to understand. We had used a witnessing position in earlier conversations, and she readily agreed. Then Mitchell began describing how he and Ellen had had more fun together than they had in a long time. Just as he was really relaxing and feeling comfortable Ellen "sidled up and initiated sex." Mitchell described how he had jumped up and stormed out of the house, leaving Ellen in tears. I wondered what might have happened if he had stayed with the relaxed and comfortable feeling. Mitchell looked at me and said, "So you are asking me to go through motions that feel dishonest and distasteful and make me anxious about the next time? If I do that, all that is left for me is either to withdraw or to be honest, knowing that Ellen will be mad. Is that good for our relationship?"

I apologized and asked Ellen what she understood. She said that she knew that Mitchell was unhappy, and so was she. "We have a dance of going back and forth from focusing on sex to avoiding it, feeling stuck, spinning in neutral and spiraling down together. We told you it was an unsolvable problem."

After this meeting, I thought about how I seemed to have entered the dance with them.

Shortly before our next meeting, a colleague with whom I had dinner plans arrived in my waiting room an hour and a half early. We sorted out the time confusion, and I said I had one more couple to meet with before I was free. My colleague volunteered to be an outsider witness for the couple, and when Matthew and Ellen arrived, I gave them the option of including an outsider witness and they agreed.

In this fifth meeting, Ellen spoke about how she felt like they really didn't have a marriage, but instead a roommate relationship, and that this made her feel like a fraud in front of friends and family members. Thinking about how I was caught up in seeing the problem the same way that they saw it at our last meeting, I thought it might be useful for all of us to unpack our understanding (and the dominant understandings) of marriage.

I asked what makes something a legitimate marriage. Ellen thought that a legitimate marriage should be a partnership in which two people were committed to building a life together, had a sexual relationship, and loved each other. I asked more about the sexual relationship. Ellen seemed a bit flustered but said, "Well, at least, occasional sex." I asked if it would still be a legitimate marriage if the sex was great, there was a commitment to build a life together, but that the two people were not in love. Ellen thought that that would still be a legitimate marriage. "So," I said, "not all of the conditions have to be there?" She looked confused but nodded. Mitchell, who had been sitting with his head bent toward the floor, sat up and looked at Ellen. I asked, "Where do you think this set of ideas comes from?"

Ellen pondered this for a bit and said, "Culture, family, the media . . . " I asked if she thought it changed over time or was different in other cultures. "Yes," she said, "but we live in this culture."

"Yeah," I said, "I just wondered if there is flexibility or room for variation."

" . . . If both people agree," she said.

I asked Mitchell if the conversation I was having with Ellen was a familiar one or an unusual one. "Unusual," he said, and explained that they both had taken for granted something about what a marriage should be and that he felt guilty having not been sure when he entered into it that he could live up to this image but hoped that he could. "Maybe it wasn't right of me to get married knowing that."

"Okay," I said, "but this conversation was different. Where did it take you?"

"It gave me the idea that maybe we could agree on something different or have some flexibility without it being a sham."

My colleague serving as an outsider witness said that what stood out to her was the idea of being a fraud by not living up to the definition of marriage. One of the reasons that this stood out to her was that she had seen several couples for whom sex was not part of their marriage. For most of them, this came later in the relationship, but like Ellen and Mitchell, they kept it as a guilty secret. Our therapy conversation had her wondering if people could escape secretiveness and worry if it was more commonly known that some people had viable marriages without sex.

When I asked Ellen and Mitchell for their reflections on the outsider witness reflections, both said that it felt good to speak of this in front of someone else and "pretty amazing" to hear that it wasn't such an unusual problem. "Maybe," said Mitchell, "we could have a legitimate marriage without sex."

"Maybe," said Ellen, but she sounded less positive about this idea.

At the sixth meeting, Ellen and Mitchell agreed that things were better. They were kinder to each other. Mitchell continued to feel hopeful. Ellen said that she could imagine a different kind of marriage that could feel legitimate, and although she didn't want to break up with Mitchell, she wasn't sure that that was what she wanted for the rest of her life. I assured Ellen that I heard her and asked if it was okay to talk about what she could imagine when she thought about a different kind of marriage. She nodded, and I asked if she could tell me about something in their relationship that supported her imagining a different kind of marriage and not wanting to break up with Mitchell.

Ellen took a deep breath, smiled at Mitchell, and said,

> "Mitchell has millions of allergies. I love being outside and gardening and jogging and swimming. I like eating outside on the deck. But Mitchell is so miserable with his allergies that he wants to be inside all the time. We have to think about the material in the furniture, and different seasons and all kind of things I've never thought about before. I grew up with pets and always loved dogs, but Mitchell is allergic, so I knew when we started living together that I would never have one again. A few months ago, I was gone for 10 days on a business trip and when I got home and Mitchell opened the door, there was the cutest, sweetest puppy you've ever seen, wagging his tail and yapping at me. And there was Mitchell petting him!"

Ellen explained to me that Mitchell knew how much Ellen loved dogs, and he told her he "put himself in her boat." He talked to his allergist and took great care in following his suggestions and treatment in preparation.

I asked many questions to bring forth a vivid, detailed story of Mitchell's finding the puppy, questions about what thoughts and feelings guided this decision, questions about the preparations he made, and why it was worth risking a big allergic reaction, and how he imagined Ellen would respond and why that was important. All three of us got to hear about what these expressions told Ellen about Mitchell and about their relationship, and how Mitchell's getting the puppy connected with other experiences they had lived through together.

When I asked Ellen, who had been in a witnessing position as Mitchell answered my questions, what she learned about what was important to Mitchell from what he had relayed, she said it showed his love, his willingness to put her at the center of his life. It was a clear demonstration that he noticed what was important to her.

These puppy experiences, once they had been told and retold in detail, put Mitchell and Ellen in touch with other experiences that had laid the groundwork for these more recent ones. I heard stories of other surprises they had given each other and other dreams they had made come true for each other.

An unanticipated consequence of having the puppy they named Scooter was the physical relationship they have with him. As they played with him, Scooter put Mitchell and Ellen in a different physical relationship with each other that was delightful for both of them. Mitchell described this relationship as being playful, comfortable, relaxed, and fun. Ellen nodded in agreement.

I asked if this kind of physical relationship had a history. At first, they said "no," and then Ellen said, "Well, it's different, but I'll tell you what I'm thinking about. The year before we got married, I broke my ankle playing hockey. I relied on Mitchell to help me adjust and get through the recovery."

When I asked her to tell me more about it and particularly what had her thinking about this as part of their physical relationship, Ellen said, "I was physically dependent on Mitchell and I appreciated his combination of strength and gentleness, his ability to anticipate and respond to what I needed, and how much pleasure I took in this physical closeness."

I asked Mitchell what it was like to hear Ellen's description of his actions. "Interesting," he said.

"Why is it interesting?" I asked.

"As she was talking," he said, "I realized I showed my love. I didn't know I could show it in a physical way."

At the next meeting, I read my notes and asked how things had continued. Mitchell said that the previous meeting had been mind-blowing. In hearing Ellen talking about his strength and gentleness and physical touch, he said that he was seeing himself in a way that he had never seen himself before and that it didn't fade. He continued seeing himself in this new way, and it added a whole layer of experience to his life. He described feeling himself move and walk and pick up things, feeling the physicalness of experience. But not just that, he also described seeing himself expressing love.

I began to ask Ellen what she had noticed, but Mitchell interrupted and said, "I have to say one more thing. . . . This is terrifying! If I continue in this way, there will be moments in which Ellen will think we are about to have sex and then I probably won't be able to do it or I'll change my mind in the middle and everything will come crashing down. So it might be better to go back to the way it was."

As I was thinking about how to respond, Ellen said, "I don't care about sex! I care about love. I think that anything we do to express it is okay . . . anything! It doesn't matter if we stop in the middle or whatever!"

We met two more times. In the seventh meeting, we talked about the difference in sex and making love. Mitchell was particularly gratified to hear that many, many acts besides sexual intercourse counted as making love to Ellen. Laughing, but seriously, Mitchell said that he thought he was a good lover. Ellen agreed. Mitchell also said that because Ellen had said that it didn't matter if they stopped in the middle, and that he believed her, he no longer turned off at the first sign of a sexual feeling. Instead, he could see where it took them and know that no matter where that was, he could be loving. He realized that he had thought of sex as a test of love and with that idea banished, he felt more hopeful and more free.

Our eighth and last meeting was a month later. Ellen and Mitchell reported that their relationship continued to be strong and loving. In looking back at what had been helpful, Ellen said that understanding the difference between sex and love and discovering that she and Mitchell were thinking they were focused on the same thing, but really were not, was helpful. "When the focus switched to love," Ellen said, "everything changed!"

Mitchell said, "For me, it was the moment when I saw myself through Ellen's eyes and realized that my touch was loving and had been all along. I feel like beginning with that moment I got to know myself in a different way, and I realized that I have a lot to offer in this relationship."

Ellen said that as their relationship became more physical, it also became more sexual, and that they had talked about it. The sexual part was better for both of them. They also agreed that even if it had not gotten better, even if the sex was forever an unsolvable problem, it would no longer be the problem at the center of their relationship. "Love is at the center!" Ellen said.

Mitchell agreed.

CONCLUDING COMMENTS

One of the joys of doing this work is that we get to witness the many and varied stories that members of couples tell. This witnessing has taught us that there are always experiences that stand outside of, and would not be predicted by, problematic stories. We never know exactly what alternative stories these experiences will contribute to, but as we inquire more closely into the experiences, stories unfold and new possibilities emerge. It is not easy to escape the dictates of idealized images and cultural norms that so easily encourage people to neglect their relationships or find them lacking. We admire the commitment and persistence of all the couples who have opened their lives to us and have taught us so much about how to work with couples. Much of what we offer in this chapter is insider knowledge we learned from couples who have entrusted us with details of their relationships.

SUGGESTIONS FOR FURTHER STUDY

Dickerson, V. C. (2012). Patriarchy, power, and privilege: A narrative/poststructural view of work with couples. *Family Process, 52,* 102–114.

Freedman, J., & Combs, G. (2002). *Narrative therapy with couples . . . and a whole lot more: A collection of papers, essays, and exercises.* Adelaide, Australia: Dulwich Centre.

Hare-Mustin, R. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33,* 19–35.

Payne, M. (2010). *Couple counselling: A practical guide.* Thousand Oaks, CA: SAGE.

Percy, I. (2007). Composing our lives together: Narrative therapy with couples. In E. Shaw & J. Crawley (Eds.), *Couple therapy in Australia: Issues emerging from practice* (pp. 139–158). Melbourne: PsychOz.

White, M. (2004). Narrative practice, couple therapy, and conflict dissolution. In M. White (Ed.), *Narrative practice and exotic lives: Resurrecting diversity in everyday life* (pp. 1–41). Adelaide, Australia: Dulwich Centre.

REFERENCES

Adams-Westcott, J., Dafforn, T., & Sterne, P. (1993). Escaping victim life stories and co-constructing personal agency. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 258–271). New York: Norton.

Anderson, H. (2012). Collaborative relationships and dialogic conversations: Ideas for a relationally responsive practice. *Family Process, 51,* 8–24.

Audet, C., & Paré, D. (2018). *Social justice and counseling: Discourse in practice.* New York: Routledge.

Bateson, G. (1980). *Mind and nature: A necessary unity.* New York: Bantam Books.

Baumgartner, B. (2013). It ain't over: Marriage (in-) equality and queer assimilation. *International Journal of Narrative Therapy and Community Work, 2,* 79–83.

Besa, D. (1994). Evaluating narrative family therapy using single-system research designs. *Research on Social Work Practice, 4,* 309–326.

Bruner, J. (1986). *Actual minds, possible worlds.* Cambridge, MA: Harvard University Press.

Carey, B. (2007, May 22). This is your life (and how you tell it). *New York Times.* www.nytimes.com/2007/05/22/health/psychology/22narr.html?_r=0.

Carey, M., Walter, S., & Russell, S. (2009). The absent but implicit: A map to support therapeutic inquiry. *Family Process, 48,* 319–331.

Carter, E., Papp, P., Silverstein, O., & Walters, M. (1984). *Mothers and sons, fathers and daughters* [Monograph Series 2(1)]. Washington, DC: Women's Project in Family Therapy.

Cohen, S. M., Combs, G., DeLaurenti, B., DeLaurenti, P., Freedman, J., Larimer, D., & Shulman, D. (1998). Minimizing hierarchy in therapeutic relationships: A reflecting team approach. In M. Hoyt (Ed.), *Handbook of constructive therapies: Innovative approaches from leading practitioners* (pp. 276–293). San Francisco: Jossey-Bass.

Combs, G. (2018). White privilege: What's a family therapist to do? *Journal of Marital and Family Therapy, 45,* 61–75.

Combs, G., & Freedman, J. (2012). Narrative, postructuralism and social justice: Current practices in narrative therapy. *Counseling Psychologist, 40,* 1033–1060.

Combs, G., & Freedman, J. (2016). Narrative therapy's relational understanding of identity. *Family Process, 55,* 211–224.

Combs, G., & Freedman, J. (2018). The therapist as second author: Honoring choices from beyond the pale. In C. Audet & D. Paré (Eds.), *Social justice and counseling: Discourse in practice* (pp. 85–97). New York: Routledge.

Derrida, J. (1978). *Writing and difference.* Chicago: University of Chicago Press.

Dickerson, V. (2013). Patriarchy, power, and privilege: A narrative/poststructural view of work with couples. *Family Process, 52,* 102–114.

Duvall, J., & Béres, L. (2011). *Innovations in narrative therapy: Connecting practice, training, and research.* New York: Norton.

Epston, D. (1993). Internalizing discourses versus externalizing discourses. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 161–177). New York: Norton.

Epston, D. (1999). Co-research: The making of an alternative knowledge. In *Narrative therapy and community work: A conference collection* (pp. 137–157). Adelaide, Australia: Dulwich Centre.

Epston, D. (2000, May 11–12). *Crafting questions for narrative practice.* Workshop presented at Evanston Family Therapy Center, Evanston, IL.

Etchison, M., & Kleist, D. (2000). Review of narrative therapy: Research and utility. *Family Journal, 8,* 61–66.

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York: Pantheon Books.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972–1977* (C. Gordon, Ed.). New York: Pantheon Books.

Foucault, M. (1985). *The history of sexuality: Vol. 2. The use of pleasure* (R. Hurley, Trans.). New York: Pantheon Books.

Fox, H. (2003). Using therapeutic documents: A review. *International Journal of Narrative Therapy and Community Work, 4,* 25–35.

France, C., & Uhlin, B. (2006). Narrative as an outcome domain in psychosis. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 53–67.

Freedman, J. (2012). Explorations of the absent but implicit. *International Journal of Narrative Therapy and Community Work, 4,* 1–10.

Freedman, J. (2014). Witnessing and positioning: Structuring narrative therapy with families and couples. *Australian and New Zealand Journal of Family Therapy, 35,* 20–30.

Freedman, J., & Combs, G. (1993). Invitations to new stories: Using questions to explore alternative possibilities. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 291–303). New York: Norton.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Freedman, J., & Combs, G. (1997). Lists. In C. Smith & D. Nylund (Eds.), *Narrative therapies with children and adolescents* (pp. 147–161). New York: Guilford Press.

Freedman, J., & Combs, G. (2000). Therapy relationships that open possibilities for us all. *Dulwich Centre Journal, 1–2,* 17–20.

Freedman, J., & Combs, G. (2002). *Narrative therapy with couples . . . and a whole lot more: A collection of papers, essays, and exercises*. Adelaide, Australia: Dulwich Centre.

Freedman, J., & Combs, G. (2004). Relational identity in narrative work with couples. In S. Madigan (Ed.), *Therapy from the outside in* (pp. 30–40). Vancouver: Yaletown Family Therapy.

Goldner, V. (1985). Feminism and family therapy. *Family Process, 24,* 31–47.

Hare-Mustin, R. (1978). A feminist approach to family therapy. *Family Process, 17,* 181–194.

Hare-Mustin, R. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33,* 19–35.

Kogan, S., & Gale, J. (1997). Decentering therapy: Textual analysis of a narrative therapy session. *Family Process, 36,* 101–126.

Laird, J. (1989). Women and stories: Restorying women's self-constructions. In M. McGoldrick, C. Anderson, & F. Walsh (Eds.), *Women in families: A framework for family therapy* (pp. 427–450). New York: Norton.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: Norton.

Morgan, A. (2000). *What is narrative therapy?: An easy-to-read introduction*. Adelaide, Australia: Dulwich Centre.

Myerhoff, B. (1986). Life not death in Venice: Its second life. In V. Turner & E. Bruner (Eds.), *The anthropology of experience* (pp. 261–285). Chicago: University of Illinois Press.

O'Connor, T., Davis, A., Meakes, E., Pickering, R., & Schuman, M. (2004). Narrative therapy using a reflecting team: An ethnographic study of therapists' experiences. *Contemporary Family Therapy, 26,* 23–40.

Reynolds, V. (2019). *Justice-doing at the intersections of power: Community work, therapy and supervision*. Adelaide, Australia: Dulwich Centre.

Seltzer, M., & Seltzer, W. (2004). Co-texting, chronotope and ritual: A Bakhtinian framing of talk in therapy. *Journal of Family Therapy, 26,* 358–383.

Weingarten, K. (2013). The "cruel radiance of what is": Helping couples live with chronic illness. *Family Process, 52,* 83–101.

White, M. (1988, Summer). The externalizing of the problem and the re-authoring of lives and relationships. *Dulwich Centre Newsletter*, pp. 3–20.

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter*, pp. 21–40.

White, M. (1995). Reflecting teamwork as definitional ceremony. In *Reauthoring lives: Interviews and essays* (pp. 172–198). Adelaide, Australia: Dulwich Centre.

White, M. (2000). *Reflections on narrative practice: Essays and interviews*. Adelaide, Australia: Dulwich Centre.

White, M. (2003). Narrative practice and community assignments. *International Journal of Narrative Therapy and Community Work, 2,* 17–56.

White, M. (2004). Narrative practice, couple therapy, and conflict dissolution. In M. White (Ed.), *Narrative practice and exotic lives: Resurrecting diversity in everyday life* (pp. 1–41). Adelaide, Australia: Dulwich Centre.

White, M. (2005). *Outsider–witness responses*. Dulwich Centre. www.dulwichcentre.com.au/michael-white-workshop-notes.pdf.

White, M. (2007). *Maps of narrative therapy*. New York: Norton.

White, M. (2011). Couples therapy: Entering couples into an adventure. In *Narrative practice: Continuing the conversations* (pp. 149–156). New York: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

CHAPTER 11

Solution-Focused Couple Therapy

Cynthia Franklin, Anao Zhang, Kristin Bolton, and Helen Taylor Yates

Solution-focused brief therapy (SFBT) is a future-oriented, strengths-based, brief therapeutic approach originally developed by an interdisciplinary group of family therapists led by Steve de Shazer and Insoo Kim Berg at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. SFBT therapists emphasize the power of language/conversation to co-construct new conversations about a couple's relationship concerns that are mutually agreed on by the therapist and partners. With the assumption that couples already have the competence, resilience, and inner resource to find solutions to their problems, the role of SFBT therapists is simply to collaborate relationally and conversationally with couples so that they can build solutions toward their preferred future. The interdisciplinary collaborators who developed SFBT included several different types of mental health professionals (e.g., social workers, psychologists, marriage and family therapists) and some nonclinical professionals, such as social psychologists and sociologists, who all worked together in the clinic to develop SFBT. It was from the work of this team that SFBT evolved as a distinct approach to therapy. SFBT is optimistic, strengths-based, collaborative, future-oriented, versatile, and has been found in research studies to be effective (Kim, Jordan, Franklin, & Froerer, 2019).

We discuss in this chapter the origins of SFBT and how it has been used in couple therapy and integrates the latest discussions on theoretical frameworks for SFBT's change mechanisms and clinical techniques for change. The latest research on SFBT is reviewed with an emphasis on the specific evidence for its effectiveness in couple therapy. A detailed case illustration demonstrates how to apply SFBT within couple therapy.

BACKGROUND

SFBT was created inductively over time while different therapists and researchers observed therapist and client interactions behind a one-way mirror at the BFTC (Lipchik, Derks, Lacourt, & Nunally, 2012). Couples were among the observed cases that came to the BFTC clinic with a range and severity of problems, from conflicts over roles, parenting, and sexual relationships to more serious problems such as interpersonal violence and child maltreatment. de Shazer and Berg, founders and directors of the BFTC, met at the Mental Research Institute (MRI), a renowned family therapy training institute in Palo Alto, California. Early in its development, the BFTC was closely connected to the MRI and strategic family therapy (Franklin, Bolton, Guz, & Gonzales, 2019). It also had considerable mutual influence with Milan systemic therapy (Selvini Palazzoli, Cecchin, Prata, & Boscolo, 1978), later postmodernism and social constructionism approaches, and narrative therapy (Hoffman, 2001). Some BFTC therapists favored emphasizing the systemic links within SFBT, while others favored emphasizing SFBT as a unique approach to therapy (Lipchik, 2002). Over time, members of the BFTC evolved to a focus on solutions as an innovative approach to change, and SFBT emerged as an independent approach to therapy.

Theoretical Foundations

Theory is important to how couple therapists think about a case and approach assessment and intervention. SFBT therapists use theory in different ways: Some integrate theories focused on family systems, (Lipchick, 2002; Reiter, 2017), whereas others move completely to solution talk as a way of helping couples (Connie, 2013).

The interdisciplinary team approach used at BFTC resulted in SFBT having a broad base in social science theories and philosophical theories. Initially, de Shazer, Berg, and colleagues aimed to develop SFBT without stating an explicit theory based in observing what was working in therapy while observing brief couple counseling and other types of counseling behind the one-way mirror. It was de Shazer's belief to keep theory minimalist in SFBT and to rely instead on careful observation and description, influenced by the work of Milton Erickson, a renowned psychiatrist-hypnotherapist. The minimalist philosophy was consistent throughout SFBT's evolution and was summarized by de Shazer in three rules:

1. If it "ain't" broke, don't fix it.
2. Once you know what works, do more of it.
3. If it doesn't work, don't do it again. Do something different (Ratner, George, & Iveson, 2012).

Relying on the minimalist philosophy and building on the constructivist communication approaches from MRI brief therapies, SFBT was conceived as using language as a tool to alter clients' preoccupation with problems to those times ("exceptions") when the presenting problem was not present (de Shazer & Dolan, 2012) and to focus on the future solutions instead of problems. Over time, the developers of SFBT engaged with and expanded on the theoretical frameworks of social constructionism and the philosophical, post-structural views of language such as Wittgenstein's language games (Bavelas et al., 2013; Franklin et al., 2019). Collaborative language theory and co-construction of meaning ground the core therapeutic processes of SFBT (Bavelas et al., 2013) and are foundational to solution-focused conversations. In a recent systematic review of 33 process studies, for example, the co-construction process was shown to be very important to therapeutic change in SFBT (Franklin, Zhang, Froerer, & Johnson, 2018). Findings from individual process studies also showed that the purposeful use of language in the form of the co-construction of meaning is a specific method that is used for building solutions with clients (e.g., DeJong & Berg, 2013; McGee, Del Vento, & Bavelas, 2005). The co-construction processes are illustrated below as we discuss assessment and intervention, and later in the couple case illustration.

Collaborative Co-Construction: "Listen, Select, and Build"

SFBT therapists do not overinterpret, conceptualize, or formulate intervention strategies when assessing couples. Instead, SFBT therapists skillfully engage in a three-step recursive process of *"listen–select–build"* to co-construct issues that the partners want to work on and potential solutions for these issues with the partners in a collaborative manner (Froerer & Connie, 2016). SFBT therapists are genuinely curious to hear from the couple (*listen*) and carefully follow alongside the couple's narrative, often using partners' exact words or their frame of reference to solicit more input. With the rich and authentic information obtained from the partners, SFBT therapists then strategically follow up on (*select*) certain narratives and move forward with the therapeutic conversation. It is through the selection of the partners' respective narratives that SFBT therapists contribute to the co-construction process. SFBT therapists intentionally select certain narratives and use various SFBT techniques to ask more questions, to listen more, and to guide the couple to identify blocks of solutions (*build*) to their presenting issues.

In the following example, a couple who is getting a divorce works on their relationship for parenting their children.

THERAPIST: What are your best hopes for improving your relationship?

NOAH: I've been feeling depressed and arguing with Hannah about the custody of our children. I'm hoping to get some help with communication.

THERAPIST: (*following up using Noah's own words*) Feeling depressed? (*Pauses and looks at Hannah.*) What help are you looking for?

HANNAH: Yeah, we're getting a divorce, and we're fighting over the custody of the kids.

Noah: It seems that I may lose custody of my kids. I'm quite sad about it.

Therapist: (*remaining open and curious rather than conceptualizing the problem* for *the couple*) So, you're getting a divorce and need help with communication. (*turning to Noah*) You're sad about possibly losing custody, right?

Noah: Yeah . . . (*Sighs.*) We had such a beautiful family, and I feel terrible for cheating on Hannah. I know I'm a terrible person.

Therapist: This is a terrible situation for you around the kids. So what are your best hopes for the help you can get during the therapy? For example, if this session was most helpful today?

Noah: (*Pauses and thinks.*) Hmm . . . I guess if I knew how to talk to Hannah about our relationship. We had a discussion about forgiveness, and I want to try and resolve the anger between us.

Hannah: I'm just interested in communication over the kids and plans for them without a lot of arguments over our relationship.

Therapist: So both of you are interested in being able to talk and communicate together and to have a better relationship around your kids. Is that correct?

This example illustrates the importance of remaining open-minded and curious about the partners' presenting issues and listening, not only validating both partners' lived experiences but also keeping a focus on the future and what the partners may desire to be different (goals). In this case, it would be easy for the therapist to jump to their own conclusions about the assessment and what solutions are needed. For example, the therapist may hear that one partner wants to solve depression and begin to assess for a diagnosis of depression. Or the therapist may hear that one partner wants help with a custody situation. In the previous example, if the therapist automatically assesses for the custody situation—why custody, what would happen in the loss of custody—the therapist may follow up with questions such as "Tell me more about the custody situation" or "Are you still involved with your kids?" In such a situation, a partner's inner feelings about their own guilt may never arise or may not arise until much later. The more an SFBT therapist hears from each partner, and follows partners' own words, the more information there is to work with. SFBT therapists want to hear as much as they can from the partners before they select a topic to follow up on.

THE PRACTICE OF SOLUTION-FOCUSED COUPLE THERAPY

The Structure of the Therapy Process

Although couple therapy may present some particular challenges, such as each partner vying for the therapist's attention and trying to get the therapist on their side, the basic structure and therapeutic processes of solution-focused couple therapy are much the same whoever attends the session. On initial phone contact, the caller may be invited to bring to the session whoever is involved. Drawing from systemic concepts, an SFBT therapist believes that individual partners who present to therapy are still encased in that relationship. Hence, it is helpful to involve both partners in therapy sessions from the beginning whenever possible (Weiner-Davis, 1995).

SFBT is typically time-limited (although with no preset session maximum). Session appointments are made one at a time, with a plan for each session to be as helpful as possible, and independent of any prior or subsequent sessions. Typically, SFBT takes about five sessions to observe progress (Iveson, 2002), but some couples only need one session. A course of therapy generally lasts one to 10 sessions, and couples can return on an intermittent or as-needed basis. Sessions may be scheduled as frequently or infrequently as the couple and therapist desire and find convenient and useful—often a week to a few weeks apart. A couple wanting another appointment in 1 week might be complimented for "wanting to get right to it," while a couple wanting to wait a month might be complimented for "wanting time to see some progress" before returning. If the partners disagree on how soon the next meeting should be, the SFBT therapist can use the disagreement to have a constructive, future-oriented conversation with the couple, as illustrated in the example below.

The couple, John and Sarah, frequently argue over decision-making strategies and style differences. In the session, John discussed how he wants everything settled quickly and gets angry at Sarah because she hesitates and won't go along with him. "She is always oppositional and putting a damper on plans." Sarah responds by stating that John is rash and pushes her. "He always wants to be right and in control, whereas I prefer to think more before I go with plans." This style difference causes conflict especially in the areas of money and social plans. In the past, these arguments have escalated to quarrels that have lasted a day or two, with John yelling at Sarah, and Sarah shutting down and moving away from John, resulting in considerable relationship dissatisfaction for both.

THERAPIST: (*to couple*) John, you prefer to have another session "real soon," and Sarah, you would like to "wait some time" before coming in. If you don't mind, let me follow up with you on that. (*Pauses and waits for reaction and then continues.*) I wonder if this is as you discussed in the session, that John likes to make quick decisions and get things settled fast, and Sarah, you prefer to think about things and prefer not to move too fast on decisions?

JOHN: Never thought of it like that but I guess could be. I want to keep the progress going.

SARAH: Hmm, I will have to think about that, but I am okay with waiting and want to see how the progress is going when we are at home.

THERAPIST: Sounds like you both want to continue to see progress and are hopeful that the therapy will help? (*John says "yes" and Sarah nods.*) So, you both want to continue the therapy? (*Both partners nod.*) So, today is Monday, let's say we have another session scheduled to keep the progress going and after that you can see how things go at home. When would that be? One or 2 weeks?

SARAH: I think two. Okay with you, John?

JOHN: I would like one, but that will be okay.

THERAPIST: Of course, you would like 1 week but I noticed you are willing to go along with Sarah. Is that right?

JOHN: Sure.

THERAPIST: Now, I have to ask you to think about an imagination question. Let's just suppose that I have to cancel the next session at the last minute due to an urgent situation at the clinic. So now, we meet again in 3 weeks instead. During our check-in, imagine for a second that you tell me, "Well, last week was fine, it was not that bad of an idea that you canceled the 2-week session. We did something together that both of us agreed on and enjoyed." (*pause*) What would that thing be, that both of you enjoyed doing during the canceled session?

In this case, the SFBT therapist follows the couple's goals and process to work with them. Specific SFBT techniques are often used in a similar adaptive manner, meaning that no technique solely belongs to certain SFBT treatment stages (e.g., initial meeting or later into the therapy) but should be delivered flexibly to maximize the principles of SFBT, including a future-oriented, strengths-based, cooperative relationship between partners and therapist, and solution-focused and collaborative co-construction (Franklin et al., 2018). While some SFBT techniques are used more often during certain treatment stages—for example, miracle questions are commonly used at the beginning stage of SFBT sessions to help set a goal—it should be within the therapist's purview further into the sessions to use miracle questions when appropriate.

The Role of the Therapist

The SFBT therapist serves essentially as a conversation facilitator, interviewing the couple purposefully (Weiner-Davis, 1995) to co-construct new meanings about the problems and changes in behavioral interactions that contain solutions to what brings the couple for therapy. Consistent with the general SFBT principles, SFBT therapists endeavor to help the couple build a solution—rather than getting bogged down in "problem talk"—by asking questions strategically, listening carefully, and intentionally selecting responses from the couple to highlight and facilitate a couple's goals or preferred future.

When compared with individual-based SFBT, an added dynamic facing SFBT couple therapists is the facilitation of conversations between the partners, as well as the therapist's conversations with the couple as one unit. The interview process is primarily designed to assist partners in achieving new perceptions and meanings that are essentially co-constructed by the couple with the facilitation from the therapist. Disagreements and arguments are common among couples who seek support, especially at the beginning of the therapy. SFBT therapists pay limited, if any, attention to these problem-saturated narratives that have embroiled the couple. The therapist may act within a session to redirect the attention of the couple away from the power struggles and arguments by saying something like "We will get back to that" and moving the conversation in a new direction toward a solution by asking new questions. SFBT therapists view disagreements between the partners as valuable opportunities to access more narratives from the couple from which to select and, consequently, to build solutions.

JEFF: (*to wife, Sophia*) You always do this, every time, when I hope to have a conversation with you about us. You just shut down and push me away. I am so tired of it.

(Therapist looks at Sophia, waiting to see if she has anything to say.)

SOPHIA: (*to Jeff*) Me pushing you away? You only talk to me when you feel like it, and with your patronizing tone, so don't put the blame on me. You are tired of it? I am! I am the one who is exhausted.

THERAPIST: (*to Sophia*) It seems to me that you had previous good experiences talking with Jeff when he was not patronizing and you were not exhausted. Would you say more about those experiences?

Trepper and colleagues (2012, p. 33) point out that "therapists who seem to embrace and excel in solution-focused therapy have these characteristics: They (a) are warm and friendly; (b) are naturally positive and supportive (often are told that they 'see the good in people'); (c) are open-minded and flexible in using new ideas; (d) are excellent listeners, especially in listening for couples' previous solutions embedded in problem talk; and (e) are tenacious and patient." The therapeutic alliance in SFBT is enhanced by the receptive attitude of the therapist, including an emphasis on positive couple goals. While the therapist–couple alliance is evolving and dynamic, one distinct feature of SFBT is its rejection of the idea of resistance. In SFBT, it is the responsibility of the therapist to develop a cooperative relationship with the couple, assuming that they want to cooperate. When resistance occurs in a session, it is a signal that the therapist is not in tune with the couple's goals and needs and the therapist needs to reevaluate the conversation with the couple (De Jong & Berg, 2001).

SFBT therapists view resistance as a natural protective mechanism or an individual's realistic desire to proceed slowly, or the therapist's error (i.e., what's offered does not fit the true needs of the couple; de Shazer & Dolan, 2012). Therefore, the SFBT therapist does not work against resistance but strives to listen more intensively, to select different narratives (what the couple wants to work on), and to build solutions with the couple on those nonresisting goals. Even if a couple has not been mandated to treatment by the legal system, one partner may, in fact, be under mandate if coming to therapy only under the insistence or threat of the other. With partners who are not there voluntarily, it is especially important to develop goals that appeal to each person but simultaneously are congruent with the shared goals of the couple. The SFBT therapist may use one partner's "resistance" as a starting point to co-construct mutually agreed goals.

THERAPIST: What brings you here?

EMMA: Well, Matt and I have had some issues for about 6 months, and lately, I think we've reached a point that we need to speak to a professional before it gets even worse.

MATT: Sure, whatever, no offense, but I don't think this is going to work. And the only reason I'm here is because Emma said she's going to leave me if I don't come. I don't get it, I mean, we have been fighting quite a lot lately, but couples fight, and we fight as often as other regular couples.

EMMA: [Nonverbal language shows frustration.]

THERAPIST: Matt, what I hear you saying is that you showed up today because you don't want Emma to leave you. Before we hear from Emma, can you can think of one thing in your mind, and let's say, after three visits including today, you have achieved that one thing, then Emma says to you, "I don't think we need to see the therapist anymore," in your mind, what would that thing be—if you think of just one thing?

Assessment and Goal Setting

When approaching assessment and goal setting, SFBT therapists notice behaviors, interactions, and how people describe their difficulties, and are curious about what change is wanted and how that change can happen within the lived experiences of people. SFBT therapists attempt to "keep it simple" by taking the patient seriously. Primacy is given to couples' experiences, goals, ideas, values, motivations, and worldviews, which are respectfully accepted as valid and real.

Assessment is not treated like a distinct phase of therapy; rather, it is an ongoing process that takes place across a conversation and unfolds in language with each question and each client and therapist interaction. In this regard, every question that is asked is co-constructed between couple and therapist and is interventive. This has been explained in different ways by authors (e.g., "assessment as intervention"; Jordan & Franklin, 2021), and questions as being interventive and not neutral (McGee et al., 2005). While a collection of previous/historical information allows couples a sense of being heard and acknowledged, and provides an opportunity for exploring couples' idea about what would be helpful, especially in their own frame of reference, the unchanging thrust of SFBT is present- to future-oriented, while the past is used as a resource.

Past history from a couple is used as a resource to help couples develop solutions. For example, even when hearing about couples' version of the past, SFBT therapists' attention primarily focuses on past exceptions and successes, and how couples can do more of what worked before at the present moment or in the future. Using the history as a resource, a therapist may ask about when the couple met and what attracted them to one another, and use that information to point out exceptions to the current complaints and experiences of one another. Exception strategies are also interspersed with empathic and reflective comments that continuously validate both partners' experiences.

The assessment focuses explicitly on what the couple brings to the therapy room, such as presenting problems and observable behavior patterns, and uses what the couple provides to help them construct solutions. Instead of exploring problems in detail, an SFBT therapist will quickly shift the conversation toward constructing a goal (what the couple wants to change). Constructing a goal requires a series of questions and reflections that happen within the beginning contact with couples, such as "What would have to happen in your relationship for this therapy to work for you?" or "What would tell you that the therapy is working?" or "What are your best hopes for your relationship?" Presented with such questions, couples often dive into their problem descriptions and complaints instead of goals and what they want to be different. So, they may say, for example, "I want my partner to stop yelling at the kids" or "We cannot communicate and we argue all the time." It is the job of the solution-focused therapist to assess and understand what each partner wants to be different and to intervene to help the couple with their goal construction by asking specific questions that make the goal behaviorally specific, and to help each partner understand the requests.

The therapist attempts to unite the couple and to build a consensus toward goals. For example, the partners may both express hostility in speech but may want to work out their relationship, and the therapist might say, "It seems that each of you are working very hard to make your relationship work out. Is that right?" Both may want more time together while they fight over ways to make that happen. The therapist might say, "So you both want to spend more time together. You must care about each other to want to find more time for your relationship." SFBT couple therapists also use scales, usually anchored on 0 to 10 or 1–10 to assess a couple's perceptions of the severity of their presenting problems and progress toward their goals. Scaling interventions are described in more detail below.

Process and Technical Aspects

"Techniques" or "interventions" often connote an idea that the therapist does something to the couple. The SFBT approach instead focuses on collaborative and solution-building conversations between the therapist and partners rather than the therapist doing something to the couple. Therefore, it is important to keep in mind that specific techniques in solution-focused couple therapy should always be viewed in relation to the principles of SFBT, as well as its change mechanisms. The eight SFBT skills outlined by the Solution Focused Brief Therapy Association's treatment manual (Trepper et al., 2012) include best hopes, scaling questions, therapeutic breaks, genuine compliments, miracle question, exceptions, goal setting, and relationship questions. The primary SFBT mindsets include future-focused, strengths-oriented components, and recognizing the client as expert.

Solution-focused couple therapy is more than a set of techniques and procedures; rather, it is foremost and primarily a style of conversation. As Shilts (2012) writes:

> A good brief solution-focused therapist needs to address the situation from at least two different perspectives. One must consider the technical pieces of the model: that is, the miracle question, exceptions, scaling, and so forth. The utilization and timing of the techniques are essential with any case. However, beyond the technical ideas is the need to incorporate the human element in therapy and skillfully weave these questions into the process. . . . Every case is different, but the model is a constant. (pp. 133, 135)

Solution-focused couple therapy is best defined by how the therapist thinks about and approaches the couple, and not by any set of techniques, procedures, or formulaic models of delivery. In the solution-focused approach, the therapist helps partners make connection, then gets out of the way and lets them construct their own solutions.

Individual Session Structure of Solution-Focused Couple Therapy

de Shazer and Berg (1997, p. 123) outlined the formal characteristics of a "classic" SFBT session:

1. At some point in the first interview, the therapist will ask the "miracle question."
2. At least once during the first interview and at subsequent ones, the couple will be asked to rate something on a scale of "0–10" or "1–10."
3. At some point during the interview, the therapist will take a break.
4. After this intermission, the therapist will give the couple some compliments, which are sometimes (frequently) followed by a suggestion or homework task (frequently called an "experiment").

The previous session structure has the advantages of being flexible and includes key elements to be included in a session.

Other authors have proposed a specific structure for SFBT sessions, offering a beginning, middle and ending stage (Franklin, Ding, Kim, Kelly, & Tripodi, 2022; Greene & Lee, 2011). The session begins with a rapport-building process that also involves starting with questions about strengths of the couple and of individual partners. After strengths have been explored, the therapist asks a question that starts the process of goal construction. It is very important to get a detailed description of the goal or desired future that the couple wants. It is expected that individuals within the couple relationship may envision different goals, and the therapist will include both and try to build a consensus toward mutual goals, as mentioned previously. From the point of goal construction, the therapy conversation progresses in the middle phase toward solution talk through an ongoing conversation about exceptions, solutions, and what will be different in the relationship in the future. Near the end of a session, there is a shift in the conversation toward reflections about key points from the current session and session wrap-up. Part of the wrap-up will be next steps and a request for commitment toward those steps. The request for commitment is believed to be an important part of change moving forward. The session ends with plans for the future in the form of solutions to continue in the future and discussion about the desire for another session.

Presession Change Questions

It is often effective to recognize the seeds and roots of change that exist before the first session. Between the initial contact with the couple (i.e., the initial call to schedule an appointment) and the first session, the therapist may make a request that helps direct partners' attention toward exceptions to the presenting issue—times or incidents when the presenting complaints are not present. "Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your [family, life, marriage, or relationship] that you want to continue to have happen." This question is considered as one of the signature techniques of SFBT, as it often effectively shifts perspectives of the partners. It presupposes that something positive is happening and noticeable by the couple. Discussing at the session what was noticed ("eliciting presession change") can help to consolidate and amplify useful new awareness.

Goal-Formulation Question

The SFBT therapist typically starts the initial session by asking one or more of the following questions:

"What needs to happen in this therapy for it to be worth your while to come today?"
"What are your best hopes for the therapy?"
"How do you see the situation?"
"What's your understanding of what would be helpful?"

The therapist solicits responses from both partners, then makes an effort to negotiate, if applicable, any discrepancy that exists between them.

> "I have a question that I want to ask each of you individually first, and then together as a couple. [pause] What would need to be different or need to happen by the end of our first session for you, so that you would walk out of the session, say 50 minutes from now, and think 'Well that session was useful and not a waste of time'?"

The partners may come up with similar or compatible goals, and the therapist can formulate additional goals using additional techniques described below. It is common, however, that partners' individual goals conflict with each other. One technique to facilitate agreement between partners is to use relationship questions.

Relationship Questions

SFBT therapists often use relationship questions for the purpose of exploring the couple relationship and what is desired for change. The relationship question also helps an individual think about what the other person wants them to do differently and promotes a more collaborative and reflective way to think about what may be needed to do to solve the problem between the individual and the partner. These types of questions may also meet with less defensiveness than asking clients to directly change, instead opening doors to explore what is desired and needed from each partner. For example, the therapist may ask: "When your partner is being more the way you want them to be, what will they see you doing differently that will tell your partner that their changes are having a meaningful effect on you? What will your partner notice that is different about you when you're responding to their requests? What will tell your partner—that you are on track to solving your relationship problems?"

In solution-focused couple therapy, the therapist does not ask the relationship question with any preset agenda except to facilitate the co-construction of mutually agreed-upon treatment goals between the partners. The relationship question, like many other solution-focused techniques, primarily solicits more information for the therapist and partners to work with toward facilitating mutual goals collaboratively.

Miracle Question

Miracle questions are often used to help set goals and are particularly helpful when couples are having difficulty describing their goals or what is desired in the future. The spirit of the miracle question is to invite the partners to describe important details of their preferred future—information the therapist can use to facilitate collaboration toward shared goals. The miracle question is often asked in varied ways but, in general, uses the following format:

> "I have a question for you that may take some imagination. Suppose the two of you finish your session today and go home. You continue your day as usual, and then you go to sleep. [pause] While you are sleeping, a miracle happens [pause], and the problems that brought you here are solved. But because you are asleep, you don't know this miracle has happened. And the next day, when you wake up and start your day, what will be the first things you notice that are different? [Or, alternatively, 'What will you notice your partner doing differently that will tell you something has changed?']"

Relationship questions can then be used in response to the partners' responses to the miracle question—as exemplified in the following exchange:

MIGUEL: Well, she may actually be in the bed but not complaining to her mother about how terrible I am.

THERAPIST: Okay, let's say if she is in bed with you. What would you do differently so that Rosa would notice that you appreciate her staying in bed and not complaining to her mother?

MIGUEL: Well, I may hug her and tell Rosa that I love her.

THERAPIST: (*to Rosa*) Rosa, if the first thing Miguel does after he wakes up is to hug you, how would that make you feel differently?

The spirit of the miracle question (and in conjunction with the relationship question) is to gently lead the couple from "one step behind," without imposing anything that does not directly come from the couple; that is, the therapist always uses the couple's own frame of reference. For example, continuing the previous example:

ROSA: I would feel very different. I would feel loved and valued by him.

THERAPIST: What would you do differently, Rosa, if Miguel makes you feel loved and valued?

ROSA: I'm probably not going to spend all my time on the phone with my mom, and spend more time talking with Miguel and do more things together that we used to enjoy.

Getting Specific Details: Painting the Picture

Once the therapist finds narratives from the couple that are constructive toward a positive goal, the therapist will use another technique to further co-construct concrete goals that are acceptable to both partners, getting specific details—painting the picture. Getting the details of what the desired future actually looks like is very important to the therapy process in SFBT because it helps the couple think differently about their relationship and problems and to construct things they can do to solve their problems. Descriptions of the miracle promote further reflection, visualization, and description of the solution the couple is seeking and helps them in their solution-building efforts.

For example, following from the previous conversation, the therapist may ask, "Would you tell me more about what you meant by 'do more things together that you used to enjoy'? Would you give me some details? What would you do? How would you know that you are doing something you both enjoyed?"

The therapist would then continue the conversation with both partners to co-construct specific, concrete, and actionable goals to work toward the next week (as an "experiment") or for the rest of the couple therapy.

Quite often, therapists may find a couple at the moment having "too many" disagreements whereby neither partner is willing to engage in solution-focused talk but rather continues to focus on disagreements or conflicts. The solution-focused therapist in most of these situations would simply "disregard" or overlook the partners' focus on disagreements and instead reorient the couple using a variety of SFBT techniques, including exception questions, coping questions, scaling questions, and others described below.

Exception Questions

Exception questions are intended to identify times when the presenting problem has not been present. Exception questions explicitly elevate the couple's awareness of their abilities to make a positive difference simply by doing what they have done already. The search for exception vividly reflects one of the three basic principles of solution-focused therapy: "Once you know what works, do more of it." In couple therapy these questions may add the benefit of both partners listening to exceptions together, and this may help them think more hopefully about their relationship and problem areas.

For example, the therapist might use any one of the following questions:

"When in the past might the problem have happened but it didn't [or it was less intense or more manageable]?"

"When have you noticed that the two of you do better with this problem?"

"How have you let your partner know when they've done something that makes a positive difference to you?"

Most times, couples do come up with exceptions or previous successes. However, when the couple does not offer any exception or success, the first thing the therapist would do is to follow up by asking, "Nothing at all?" And if there is still no luck, by asking, "Both of you have told me about the great relationship you once had. How were similar conflicts resolved then?"

Coping Questions

Coping questions are intended both to acknowledge the difficulty and painfulness of some situations and to highlight the partners' available resilience and inner resources. These types of questions highlight what the couple is already doing that works in their lives and compliments them for their efforts. Coping questions are very valuable in cases where there is a lot of trauma or crisis, as it is important to stabilize couples before asking them to change. A solution-focused therapist acknowledges their struggles and does not immediately ask them to change without empathizing appropriately and acknowledging both their life struggles and their past efforts to solve the problems. In this regard, coping questions can be used in the beginning of a session in the opening remarks and rapport building, and at different times in the session to support the couple emotionally and to build a collaborative relationship between the couple and the therapist. Coping questions may also help the therapist co-regulate the emotions with the partners by acknowledging their concerns and strengths and letting them know they are capable and competent. Exploring coping may also help couples shift away from emotional triggers toward what they are already doing that makes a difference with each other.

These types of questions may be used further to explore coping resources by thinking about what the partners need to continue doing. They can be used to reinforce a plan for coping with a difficult situation or to even create a safety plan. For example, the therapist might say any of the following to affirm the couple's strengths:

"Given how bad the arguments have been, how have you managed to prevent it from getting even worse?"

"You have not been speaking to each other for a while. How did you manage to find a time and schedule today's appointment?"

"Both of you are here today, fighting off the argument. What else did you do to cope with the arguments?"

"You are doing a lot to cope with this situation [name what they are doing] while you seek some new ideas. What coping strategies do you think will continue to be most helpful to you now? If I understand correctly, when Juan pushes you away, you get mad at him and yell. You both have found a way for taking a break and then making up. I am really impressed that you are able to make up so quickly. What is most helpful about the way you currently cope with your disagreements?"

Agency Questions

Agency questions are intended to call attention to partners' self-determination and self-efficacy, that is, their abilities or inner strengths to make a difference in the desired direction—individually and as a couple. The therapist wants to convey that the couple has a choice and are generally competent to solve their problems. One or both partners may feel stuck and unable to make a change, and these questions help to move them toward the possibility of change. In particular, these types of questions are used to help each person recognize their own competencies and the competencies of their partners. By using such questions, the therapist creates a supportive and encouraging environment that is conducive to collaborative, hopeful, and solution-focused conversations. Sample agency questions include the following:

"How did you do that?"

"What were each of you doing differently when you were doing better [or when there wasn't a problem, or when the exception happened]?"

"What would your partner say you could do that would encourage them to do more of the things you think they could do to make a difference? Would you agree, even though it might be hard to do it or to go first?"

Scaling Questions

In using scaling questions, partners are asked to rate relationship issues on a scale from 0 to 10, with 0 being the absolute worst and 10 being the best. Solution-focused therapists use scaling questions in a unique way to help shift discourse toward a solution (rather than a problem) focus. For example, for any nonzero but low responses (e.g., a couple rates their current relationship as a 2 out of 10), the therapist may respond by asking, "What makes you rate your relationship at the score of 2 rather than a score of 0 [or 1]?" By doing so, the therapist actively disengages from the couple's negative evaluation and, instead, attends to positive elements that raise the score above zero.

Another use of the scaling question is to co-construct actionable steps with the couple. For example, the therapist might say, "You both rated your current relationship as a 2 out of 10. What needs to happen so that we can move from 2 to a score of 2.5?" Such scaling questions can also be applied to issues of hope, motivation, or similar aspects of the couple's relationship to identify specific actions or other indicators that would raise the partners' evaluations by even a small, discernible amount.

When to Intervene, and for What

The purpose of solution-focused couple therapy is to help the partners build solutions they find acceptable. If the couple is making progress that is adequate and satisfying to both partners, it is important to adhere to the SFBT's principle "If it works, don't fix it." In these instances, the therapist's job is simply to encourage the couple to do more of "what's working"—that is, previous exceptions or past success.

If one or both partners get stuck, the couple is likely to be bogged down in "problem talk" or "conflict talk." Then, the therapist focuses the work on facilitating solution talk and co-constructing pieces of solution to their presenting challenges. The key job of the solution-focused therapist is to disrupt the couple's problem or conflict talk, often by ignoring such talk and instead focusing on clues or signs of solution talk, then co-constructing solutions with the couple. The therapist intervenes, interrupting problem-focused talk before it escalates into demoralizing bickering, cycles of blaming and defending, accusations, and unhappy crescendos. The therapist skillfully uses various solution-focused techniques such as those described earlier to shift the couple's attention to solutions and their preferred future.

Subsequent Sessions

When a couple returns for a subsequent session, the solution-focused therapist endeavors to co-create a safe and cooperative situation, then inquiries about progress, seeking detailed descriptions of any movement toward the couple's desired outcome, and the couple's positive engagement in attaining the positive movement. The therapist then engages in conversations with the couple about next steps that each partner can take to keep building the solution.

Some couples come back for a subsequent session but report a lack of discernible progress or even deterioration or worsening of the presenting problem. The therapist may use a coping question by asking, "How did you keep the issues from getting worse" or "I hear you both talking about it getting worse, yet, I am encouraged to see you both showing up today. What's motivating you both to keep trying?" In these scenarios, focusing further on the problem or conflict only increases the couple's frustration, and should be avoided in solution-focused couple therapy.

Termination

Solution-focused couple therapy ends when the partners are satisfied that their goals have been adequately met or achieved. This can be gauged using the couple's responses to the future-oriented goal-setting question—for example: "How would we know that you have received and achieved what you are here for, so that we can stop what we are doing here?" or "What needs to happen, for example, after several sessions of our meeting, so that you would walk out of this room and look at each other, thinking, 'I don't think we need to come any more?' "

As implied by the title of the approach, solution-focused therapists endeavor to become obsolete and for the therapy to be brief. The goal is to get the couple out of therapy and actively and productively involved in living their lives. The approach is minimalistic in two related senses: (1) theoretical elegance, staying close to the couple's goals without introducing unnecessary and potentially distracting topics, and (2) remaining short-term, using the minimum of necessary sessions. Most importantly, solution-focused couple therapists should be ready to terminate whenever the couple feels ready to move on, while keeping the possibility open for future sessions.

Common Therapist Errors

Being Either Too Problem-Focused or Problem-Avoidant

Therapists are often trained and oriented toward problems and pathologies (i.e., trying to figure out what the problem is and then fix it). In addition to highlighting negativities, therapists can engender opposition by trying to force the couple to go where they don't want to go or they are not ready to go, which in turn causes resistance. On the other side, therapists may be too quick to focus on nothing but solutions, avoiding any problem talk, without listening and sufficiently validating the partners' emotions and experience. The therapist needs to be patient and to move at the couple's pace toward solution talk and solution building, and maintaining a cooperative relationship. Whereas the therapist should focus on strengths and solutions, it is okay to talk with the couple about their problems as a starting point. In addition, it can be important at times to revisit the couple's presenting issues and to connect these issues with the couple's past exceptions, previous successes, preferred future, and strengths.

Being Too Focused on the "SFBT Approach"

Solution-focused therapists at times may focus too much on delivering "the SFBT approach," that is, emphasizing specific SFBT techniques without fulfilling the true spirit of SFBT—a style of conversation that helps the couple to shift their attention and orientation to positives, strengths, and solutions. Solution-focused couple therapy should not be "model-driven" or "technique-driven" at the expense of the therapeutic alliance or the focus on strengths and collaboration. SFBT, if delivered in a formulaic manner, can result in couples feeling "solution forced" (Nylund & Corsiglia, 1994).

Being Superficially Positive

Although solution-focused therapists generally keep a positive stance and often compliment the couple, partners can become bored with the therapist's endless and purposeless compliments. Thomas (2007) cautioned that optimism may turn into "Pollyanna thinking" in which realistic barriers and pathology are not taken into account. Sharry, Madden, and Darmody (2003) note that "a good solution-focused therapist should be flexible enough to adapt to the client's concerns, wishes and unique way of cooperating, even if it means abandoning the solution-focused model if required" (p. 90). Like all therapists, the solution-focused therapist acts in the best interests of the couple and always works to keep the couple safe and well.

MECHANISMS OF CHANGE

Authors debate whether SFBT is a theoretical versus atheoretical approach. SFBT offers no explicit theory about human behavior, personality, or how people become dysfunctional. "SFBT is, above all, an approach, a stance, a perspective, and a way to conduct a therapeutic conversation" (Simon & Nelson, 2007, p. 7). Implicit in SFBT are values such as the respect for the individual, human agency, the importance of social relationships, and the natural processes of people (e.g., how language works), and the respect for persons' ability to be resilient and solve their own problems.

Despite SFBT's atheoretical and inductive nature, research has begun to bring an empirical lens to SFBT's change mechanisms (De Jong & Berg, 2013; Franklin et al., 2018). The co-construction process has been at the core of these discussions regarding mechanisms of change. The clinical techniques used by SFBT couple therapists are believed to co-facilitate the co-construction of meaning and solution-building processes. A qualitative metasummary study on the change process of SFBT (Franklin et al., 2018) revealed that SFBT therapists intentionally and purposefully use strengths-based language and techniques (e.g., exception questions, compliments), and future-focused techniques (e.g., miracle question) to co-construct solutions and a preferred future with the clients. Consistent with the theoretical literature on SFBT, key findings of this review indicate that, all together, SFBT techniques serve one primary purpose: to facilitate a strengths-based and collaborative conversation between the therapist and clients to foster positive emotions and solutions. As the positive-spirited conversation continues, the SFBT therapist strategically engages in the "listen–select–build" process described earlier to intentionally co-construct solutions for presenting issues.

The use of common factors such as high positive regard and empathy and the facilitation of the cooperative empowering relationship between the couple and therapist are embedded within the solution-focused conversation (Franklin et al., 2018; Froerer & Connie, 2016) along with the facilitation of positive emotional responses that are believed to jump-start the couple's solution building. Blundo, Bolton, and Hall (2014), for example, described how research demonstrates the presence of hope, and the development and cultivation of hope plays an important role in the change process in SFBT:

> Hope is a significant, although not as well researched element in SFBT practice and outcomes. Future-oriented questions as well as focus on potential exceptions and desired outcomes are generative of hopefulness which, in turn, generates possibilities for change. The concept of hope contributing to change is most often referred to in general terms and is not related to specific skills or constructive questions used in solution-focused practice. (p. 56)

Kim and Franklin (2015) further expanded this line of thinking, suggesting that SFBT therapists invoke clients' positive emotions through the co-construction process. Grounded in Fredrickson's (2004) broaden-and-build theory of positive emotions, SFBT principles and techniques generate positive emotions (e.g., hope or self-efficacy), which, in turn, broaden the thought–action repertoire. Consequently, solution-focused couple therapy undoes partners' negative emotions, expands their thinking beyond a narrow focus on problems, and promotes action steps toward change.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

SFBT is evidence based (Franklin, Trepper, Gingerich, & McCollum, 2012), especially given the accumulating literature supporting its effectiveness over the past decade. Kim, Smock, Trepper, McCollum, and Franklin (2010) noted the inclusion of SFBT on three national evidence-based practice registry lists in the United States. Empirical evidence supporting SFBT continues to rapidly increase, and numerous systematic reviews and meta-analyses of SFBT studies have been published since 2010. Gingerich and Peterson (2013) qualitatively reviewed all controlled outcome studies of SFBT and identified strong support of SFBT for internalizing disorders, with comparable treatment effect when compared with other well-established psychotherapies. Following this qualitative review, additional systematic reviews and meta-analyses have supported SFBT's efficacy for Latino populations (Gonzalez, Franklin, & Kim, 2016), Chinese populations (Kim et al., 2015), work with children and families (Bond, Woods, Humphrey, Symes, & Green, 2013), and clients with comorbid medical conditions (Zhang, Franklin, Currin-McCulloch, Park, & Kim, 2018). Kim, Becci, and Brook (2019) updated the research support for the treatment effect of SFBT. After evaluating eight

SFBT systematic reviews and meta-analyses, they concluded that SFBT research has significantly grown and has contributed to its worldwide recognition.

Despite its growth in research evidence, SFBT lacks studies specifically evaluating couple therapy or a focus on specific outcomes related to the presenting problems of couples. In a meta-analysis, Kim (2008) noted only a handful of studies that addressed interpersonal and family relationship outcomes. Other, more recent reviews have noted the effective outcomes of SFBT across interpersonal and family issues (Gingerich & Peterson, 2013; Kim et al., 2019) but few researchers have made SFBT practice with couples' issues a priority for study (Franklin et al., 2019). Most studies that involve couples and family therapy address the resolution of presenting problems with adolescents and children or parenting (Bond et al., 2013; Creswell et al., 2017) and the effectiveness of SFBT in child welfare and school settings (Franklin et al., 2022; Kim, Akin, & Brook, 2019). Research suggests that when applied to the presenting problems of children or adolescents relative to parents, SFBT is a promising approach to use in couple and family therapy.

CASE ILLUSTRATION

We illustrate here the application of solution-focused couple therapy by describing the process of assessment, session structure, relational interactions, and overall treatment. This case shows how the therapist listens carefully to what is being said and selects the words and parts of the information presented by the couple that will move them toward solution talk. Through this process, the partners also change their perspectives and create their own solutions.

Background

Mark (age 38) and Chris (age 42) were referred to therapy by a community organization to help them address issues in their relationship after the couple had asked for a lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ)–affirming therapist. Mark was being seen for individual therapy to address anxiety and to overcome a history of domestic violence experienced in a previous relationship. Chris, who had not previously received mental health treatment and was eager to attend therapy with Mark, saw the sessions as a means of supporting his partner in his efforts to address his mental health and strengthen their relationship.

Because SFBT is a strengths-oriented approach, the couple's strengths, resources, and relationships will be discussed without focus on dysfunction. Mark and Chris have been in a relationship for 3 years and have recently decided to marry. Mark comes from a conservative Christian family with deep Southern roots and a cultural bias against people who identify as gay. Mark's parents believe that it is a sin to be gay, and when he came out to them as a teenager, they rejected him and expressed their disapproval. Since Mark left his small town to move to a larger city, he has had limited contact with his parents and does not return very often to the town where he was raised. He has an older sister, Samantha, who provides emotional support, as well as acceptance and love for his partner Chris. Chris was raised in a larger Southern city by Jewish parents who were very supportive of him when he chose to come out to them during college. Chris and Mark spend a lot of time with Chris's parents, who have come to love Mark as a son.

Chris and Mark have successful careers in technology, which is how they met after college. Last year, they bought a house together that they are slowly remodeling in a diverse neighborhood. They have a close community of friends in the area and are involved in a local dog rescue as volunteers. Mark sometimes complains of Chris's long work hours, and Chris is concerned that Mark has trouble saying "no" to the dog rescue. They are currently fostering four dogs in their 1,200-square-foot home.

When Mark spoke on the phone to the therapist before their first appointment, he was asked to discuss with Chris their best hopes for couple therapy before the first meeting. This technique of asking clients to begin the therapeutic process by expressing their best hopes helps to focus the sessions on their preferred future and also sets the tone of clients as the experts in the therapeutic relationship.

Session 1

The session begins with some rapport-building and strengths-oriented questions, how the couple met, and some aspects of their relationship that attracted them to one another. When prompted by the therapist, Chris indicates that the couple's best hope is to "communicate in a more productive way, so that there are less arguments and more positive interactions." As a follow-up, the therapist asks the couple to scale the quality of their communications as they currently perceive them. Scaling questions are used to gauge progress toward goals in a manner that honors partners' unique perception of their progress as opposed to using traditional psychometric scales. This helps with co-construction of the progress that is being made between the therapist and the couple. The therapist selects the exact words of the partners' "best hope" as much as possible to construct the scaling question to ensure that the partners are measuring progress toward the goal that matters to them the most. The conversation proceeds as follows:

THERAPIST: If you could score the productivity of your communication as a couple on a numerical scale, what score would you give?

CHRIS: You mean, like, rate our communication skills as they are right now?

THERAPIST: Yes, use any scale you like—1–10, 1–5, whatever makes sense to you.

CHRIS: Okay, well, hmm . . . I would give it a 3 right now out of 10. I need to work on it. I'm short sometimes, and I don't listen. I just talk too much and sometimes go on and on to make my point. It's like I have to keep explaining why I'm right. (*Looks at Mark.*) It's true, isn't it?

MARK: Well, yes. I mean you're being a bit harsh on yourself. (*Laughs.*) You do like to be right and so do I, but I think we are doing a little bit better than a 3. I'd say a 5. There is room for improvement for sure, but it's not like we are screaming at each other all the time. You are a better listener than you give yourself credit for.

THERAPIST: (*Nods and smiles slightly, looking at Chris as if impressed, then looks back at Mark.*) A better listener than he gives himself credit for?

MARK: Yes! He's a great listener. Unless it's about the dogs. Then he knows everything. (*Offers sarcastic look to Chris.*) Seriously, though, he's very patient and kind. If I get frustrated about work, he's always very calm and supportive. He will offer some advice and suggestions, but he never judges me. Even when I probably deserve it.

THERAPIST: So, Chris does not judge you?

MARK: Never. He never has, and that's why I loved him right away, the first day we met. I've been judged and convicted for who I am my entire life—by my family, my town, even my ex-boyfriend, who had no reason to judge me. Chris is not like anyone else. His acceptance of me as a person is unconditional and full. (*Eyes sparking a bit from tears welling up. Chris pats his knee.*) I'm very lucky to have him.

CHRIS: (*in a joking manner*) I have no choice. You're stuck with me now, and I'm stuck with you. We might as well support each other. No one else will put up with us!

The banter between these clients is fun, and they use it to cut tension in moments of intensity. The struggle with feeling judged is something that Mark's referring individual therapist had explained in the referral process as a major contributor to his anxiety symptoms. In this dialogue, the clients offer some opportunities for exploring problems or focusing on the past (the dogs, the ex-boyfriend). However, the solution-focused approach facilitates a shift of focus to the future and on strengths rather than deficits, so the therapist has chosen to highlight pieces of the conversation that reflect those mindsets. This includes the nonjudgmental communication process and listening skills that Mark notes when talking about Chris.

The remaining focus of the session involves the therapist summarizing and reflecting what she sees as the strengths in communication between Mark and Chris, including Mark's perception that Chris is accepting and nonjudgmental, a good listener. The therapist provides a genuine compliment that the couple is skillfully using humor to cut tension. A follow-up session is scheduled in 2 weeks.

Session 2

Mark and Chris return in 2 weeks and tell the therapist about a recent conflict they had while preparing for an event they were hosting. The couple was participating in a tour of homes in the community as a fundraiser for the dog rescue where they volunteer.

MARK: Well, I definitely didn't use my best communication skills last weekend. I was stressed about getting ready for the open house, and this event was important to me! I mean, 200 people were coming through the house in only a few hours, and there was dog hair everywhere. I still had to get the drinks and food ready, and then Chris started checking his e-mails and I guess I lost it. I screamed at him to put his phone down and help me. I was awful. We had been doing so well, and I just hate that this is how I am.

Therapist: (*listening and selecting parts of the conversation that are supportive and strengths-oriented*) This sounds very stressful preparing for the event, but it sounds like the organization means a lot to you, and you wanted to get everything right. I'd like to talk about your statement that "this is how you are." I'm wondering, since people don't always behave in the same ways, and since you said you had been doing really well, are there exceptions to the times that you are like that?

Mark: You mean, even when I'm stressed out? Well, yes, of course. I mean, the days before, we had done a really good job of making all the decisions about the open house, and we had agreed on everything. We had a pretty good plan for making it all work, even though we are busy at work, and it was actually really fun. I was trying to be more open to Chris's ideas instead of assuming that I'm always the planner when it comes to stuff like this. He actually had some pretty good ideas.

Chris: See, I'm not that bad at this stuff. You liked my conversation area idea.

Mark: Yes! That was awesome. Everyone spent the whole time out there. It was so much fun.

Therapist: So, it sounds like even though you're not always perfect in your communications and you argued before the event, you actually had more good days and moments leading up to that. I think it's great that you were able to focus on the event and work together toward something you both care about.

Mark: Yes, that event raised several thousand dollars for the rescue. We are definitely doing it again next year because it was a new event, and the feedback was that it was everyone's favorite this year.

In this session, the therapist uses the "finding exceptions" technique by asking about a time when the partners were able to use communication skills they felt good about. She shifts the focus from the single argument that occurred. This helps them focus more on their strengths and realize that although problems occur in their communication, they are not the norm. To bring the session back toward a future focus, the therapist then directs the conversation back to their original goal.

Therapist: So, even though you had that argument, and Mark, you were not proud about how you communicated, you can still move forward and refocus on your goal. What do you think you could do in the future if there is a conflict about Chris's e-mails or work choices?

Mark: I think I just need to be clearer up front about my expectations. Like just let him know that I really need his help and that I don't want us to focus on work when we are trying to do other things. Which is basically what I did . . . I just need to do it in a calmer tone.

Chris: Yeah, but really, we've had this conversation 100 times. I know that it upsets you when I work too much and, honestly, I didn't really need to be in my e-mail. It's just a reflex sometimes to check it, but it's not good for me. I need to work on my mindfulness. (*Smiles at Mark.*)

Mark: Oh, yes! He has been learning to meditate. It's adorable. (*Smiles at therapist.*)

This case illustrates some of the key principles and specific techniques of solution-focused couple therapy: to listen carefully and then build on partners' exceptions and strengths toward their preferred solution. Before the start of the first session, a "best hope" question was used to set the tone of the couple as the experts and to help the partners focus on a preferred future. In the sessions that followed, the therapist helped both partners highlight and amplify their strengths by providing genuine compliments about what was working and helping them find exceptions to the problem. She also used scaling questions during the initial session to gauge where the clients saw themselves in their progress toward their goal. In subsequent sessions, this scaling question could be repeated to help the couple continue to gauge progress and determine when therapy can be discontinued. In the solution-focused approach, the brief and co-constructive process of the work means the number of sessions is not predetermined, but rather is decided by the couple. The required number of sessions is not one more than what the partners feel is required to meet their goals. Couples like Chris and Mark may be satisfied with their progress after only two sessions but may return later if they would like to address any new issues.

CONCLUDING COMMENTS

Solution-focused couple therapy is a future-oriented, strengths-based, brief therapeutic approach that emphasizes a style of therapeutic conversation with couples rather than a set of prescribed clinical interventions. Grounded in social constructionism, solution-focused therapists emphasize the power of language and conversation in co-constructing solutions that are mutually agreed upon by both partners and the therapist. Solution-focused assessment and intervention are distinctly different from most other forms of therapy in that the solution-focused approach uses each turn in a therapeutic conversation as a starting point for further conversations that are aimed at helping couples build their own future solutions. Solution-focused couple therapy is transcultural and respects the "local knowledge" (individual, couple, familial, social) of those who seek therapy. This contributes to its worldwide adoption across different cultures.

SUGGESTIONS FOR FURTHER STUDY

Connie, E. (2012). *Solution building in couples therapy*. New York: Springer.

European Brief Therapy Association: *www.ebta.eu*

Institute for Solution Focused Therapy: *https://solutionfocused.net*

Reconnecting couples with solution-focused therapy: An intensive online course: *https://catalog.pesi.com/sales/fbh_020644_sft_organic-36293*

Solution-Focused Brief Therapy Association: *www.sfbta.org*

REFERENCES

Bavelas, J., De Jong, P., Franklin, C., Froerer, A., Gingerick, W., & Kim, J., . . . Trepper, T. S. (2013). *Solution focused therapy treatment manual for working with individuals* (2nd version). https://irp-cdn.multiscreensite.com/f39d2222/files/uploaded/SFBT_revised_treatment_manual_2013.pdf.

Blundo, R., Bolton, K. W., & Hall, J. C. (2014). Hope: Research and theory in relation to solution-focused practice and training. *International Journal of Solution-Focused Practices,* 2(2), 52–62.

Bond, C., Woods, K., Humphrey, N., Symes, W., & Green, L. (2013). Practitioner review: The effectiveness of solution focused brief therapy with children and families: A systematic and critical evaluation of the literature from 1990–2010. *Journal of Child Psychology and Psychiatry, 54,* 707–723.

Carr, A., Hartnet, D., Brosnan, E., & Sharry, J. (2017). Parents Plus systemic solution focused parent training programs: Review of evidence and meta-analysis. *Family Process, 56,* 652–668.

Connie, E. (2013). *Solution building in couples therapy*. New York: Springer.

Creswell, C., Violato, M, Fairbanks, H., White, E. Parkinson, M., Abitabile, G., . . . Cooper, P. (2017). Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive-behavioural therapy and solution-focused therapy for treatment of childhood anxiety disorders: A randomised controlled trial. *Lancet Psychiatry, 4, 529–539.*

De Jong, P., & Berg, I. K. (2001). Co-constructing cooperation with mandated clients. *Social Work, 46,* 361–374.

De Jong, P., & Berg, I. K. (2013). *Interviewing for solutions*. Belmont, CA: Brooks/Cole, Cengage Learning.

de Shazer, S., & Berg, I. K. (1997). "What works?": Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy, 19,* 121–124.

de Shazer, S., & Dolan, Y. (2012). *More than miracles: The state of the art of solution-focused brief therapy*. New York: Routledge.

Franklin, C., Bolton, K., Guz, S., & Gonzales, K. S. (2019). Solution-focused brief family therapy. In B. Fiese (Ed.), *APA handbook of contemporary family psychology* (Vol. 3). Washington, DC: American Psychological Association.

Franklin, C., Ding, X., Kim, J. S., Kelly, M. S., & Tripodi, S. (2022). Solution focused brief therapy: Interventions for at-risk students in school. In L. McCall, K. Corcoran, & A. R. Roberts (Eds.), *Social workers' desk reference* (4th ed., pp. 1115–1129). New York: Oxford University Press.

Franklin, C., Trepper, T. S., Gingerich, W. J., & McCollum, E. E. (2012). *Solution-focused brief therapy: A handbook of evidence-based practice*. New York: Oxford University Press.

Franklin, C., Zhang, A., Froerer, A., & Johnson, S. (2018). Solution focused brief therapy: A systematic review and meta-summary of process research. *Journal of Marital and Family Therapy, 43,* 16–30.

Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions of the Royal Society of London B: Biological Sciences, 359*(1449), 1367–1377.

Froerer, A. S., & Connie, E. E. (2016). Solution-building, the foundation of solution-focused brief therapy: A qualitative Delphi study. *Journal of Family Psychotherapy, 27,* 20–34.

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice, 23,* 266–283.

Gonzalez, K., Franklin, C., & Kim, J. (2016). Solution-focused brief therapy with Latinos: A systematic review. *Journal of Ethnic and Cultural Diversity in Social Work, 25,* 50–67.

Greene, G., & Lee, M. Y. (2011). *Solution-oriented social work practice: An integrative approach to working with client strengths*. New York: Oxford University Press.

Hoffman, L (2001). *Family therapy: An intimate history*. New York: Norton.

Iveson, C. (2002). Solution-focused brief therapy. *Advances in Psychiatric Treatment, 8,* 149–156.

Jordan, C., & Franklin, C. (2021). *Clinical assessment for social workers* (5th ed.). New York: Oxford University Press.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18,* 107–116.

Kim, J. S., Akin, B., & Brook, J. (2019). Solution-focused brief therapy to improve child well-being and family functioning with substance using parents in the child welfare system. *Developmental Child Welfare, 1,* 124–142.

Kim, J. S., & Franklin, C. (2015). Understanding emotional change in solution-focused brief therapy: Facilitating positive emotions. *Best Practices in Mental Health, 11,* 25–41.

Kim, J. S., Franklin, C., Zhang, Y., Liu, X., Qu, Y., & Chen, H. (2015). Solution-focused brief therapy in China: A meta-analysis. *Journal of Ethnic and Cultural Diversity in Social Work, 24,* 187–201.

Kim, J., Jordan, S. S., Franklin, C., & Froerer, A. (2019). Is solution-focused brief therapy evidence-based?: An update 10 years later. *Families in Society, 100,* 127–138.

Kim, J. S., Smock, S., Trepper, T. S., McCollum, E. E., & Franklin, C. (2010). Is solution-focused brief therapy evidence-based? *Families in Society, 91,* 300–306.

Lipchik, E. (2002). *Beyond techniques in solution-focused therapy*. New York: Guilford Press.

Lipchik, E., Derks, J., Lacourt, M., & Nunally, E. (2012). The evolution of solution-focused brief therapy. In C. Franklin, T. S. Trepper, W. J. Gingerich, & E. E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence-based practice* (pp. 3–19). New York: Oxford University Press.

McGee, D., Del Vento, A., & Bavelas, J. B. (2005). An interactional model of questions as therapeutic interventions. *Journal of Marital and Family Therapy, 31,* 371–384.

Nylund, D., & Corsiglia, V. (1994). Becoming solution-focused/forced in brief therapy: Remembering something important we already knew. *Journal of Systemic Therapies, 13,* 5–12.

Ratner, H., George, E., & Iveson, C. (2012). *Solution focused brief therapy: 100 key points and techniques*. London: Routledge.

Reiter, M. D. (2017). Solution focused couples therapy. In M. D. Reiter & R. J. Chenail (Eds.), *Constructivist, critical, integrative approaches to couples counseling* (pp. 74–104). New York: Routledge.

Selvini Palazzoli, M., Cecchin, G., Prata, G., & Boscolo, L. (1978). *Paradox and counterparadox: A new model in the therapy of the family in schizophrenic transaction*. New York: Aronson.

Sharry, J., Madden, B., & Darmody, M. (2003). *Becoming a solution detective: Identifying your clients' strengths in practical brief therapy*. New York: Haworth Press.

Shilts, L. (2012). Solution-focused brief therapy. In A. Rambo, C. West, A. Schooley, & T. V. Boyd (Eds.), *Family therapy review: Contrasting contemporary models* (pp. 133–135). London: Routledge.

Simon, J. K., & Nelson, T. S. (2007). *"I am more than my label": Solution-focused brief practice with long-term users of mental health services*. Hoboken, NJ: Taylor & Francis.

Thomas, F. N. (2007). Possible limitations, misunderstandings, and misuses of solution-focused brief therapy. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 391–408). New York: Haworth Press.

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W. J., & Franklin, C. (2012). Solution-focused brief therapy treatment manual. In C. Franklin, T. S. Trepper, W. J. Gingerich, & E. E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence-based practice* (pp. 20–36). New York: Oxford University Press.

Weiner-Davis, M. (1995). *Change your life and everyone in it*. New York: Simon & Schuster.

Zhang, A., Franklin, C., Currin-McCulloch, J., Park, S., & Kim, J. (2018). The effectiveness of strength-based, solution-focused brief therapy in medical settings: A systematic review and meta-analysis of randomized controlled trials. *Journal of Behavioral Medicine, 41,* 139–151.

CHAPTER 12

Socioculturally Attuned Couple Therapy

Carmen Knudson-Martin and Lana Kim

BACKGROUND

Therapists know societal contexts have an impact on intimate relational processes, yet how to connect macro patterns at the societal level with micro processes in couple therapy is often elusive. Socioculturally attuned family therapy (SCAFT), developed by Teresa McDowell, Carmen Knudson-Martin, and J. Maria Bermudez (2018), is a transtheoretical framework that enables therapists to connect these dots in their practice. It expands beyond ideas of cultural competence to a broader sense that what happens in clinical encounters is not neutral (Knudson-Martin, McDowell, & Bermudez, 2020).

SCAFT enables clinicians to build on enduring couple and family therapy concepts while expanding our lenses to be accountable for how what we do inhibits or promotes relational justice. The framework applies awareness of the influences of the societal context and an analysis of power to any couple and family therapy model, with the goal of inviting partners toward third-order change. In this chapter, we describe the SCAFT framework and illustrate socio-emotional relationship therapy (SERT), an approach to couple therapy that embodies socioculturally attuned family therapy principles. Clinicians may apply these practices as a primary approach or as a way to explore the role of social justice issues in other forms of couple therapy.

Toward Third-Order Thinking

SCAFT is based on responsibility toward equity and what McDowell, Knudson-Martin, and Bermudez (2019) refer to as "third-order thinking." It is part of an evolving paradigm shift in how clinicians pay attention to and organize information regarding the influence of larger contexts and use that information to guide interventions and ethical decision making. Third-order thinking has roots in Bateson's (1972) description of three levels of learning. According to Bateson:

> Learning I is change in specificity of response by correction of errors of choice within a set of alternatives. Learning II is change in the process of Learning I, e.g., a corrective change in the set of alternatives from which choice is made, or it is a change in how the sequence of experience is punctuated. Learning III is change in the process of Learning II, e.g., a corrective change in the system of sets of alternatives from which choice is made. (p. 298)

Third-order thinking is a metaperspective that makes visible how partners' ways of knowing, experiencing, and responding to each other are informed and limited by systems of systems and may replicate the status quo. Third-order thinking makes it possible to envision relational alternatives outside these constraints to create third-order change, that is, relational options beyond those prescribed by dominant societal norms.

Back to the Future

Awareness that how people live and love is intricately connected to larger societal contexts is part of the legacy of systems/relational therapies. Recognition that communication patterns and symptoms will be misdiagnosed if not examined within larger systems is foundational to couple and family therapy (Minuchin, Montalvo, Guerney, Rosman, & Shumer, 1967). Socioculturally attuned couple therapy builds on these ecological roots, "broadening the field of inquiry first before . . . looking into the problem 'in depth'" (Auerswald, 1971, p. 263).

SCAFT reflects an ever-evolving critical contextual lens within systems/relational therapies. Feminist and critical multicultural therapists considered how dynamics of privilege, oppression, and marginalization are replicated in intimate relationships (e.g., Boyd-Franklin, 1989; Hare-Mustin, 1978; McGoldrick, Anderson, & Walsh, 1989). Social-constructionist thought (Gergen, 1997) helped clinicians view cultures and identities as fluid, multivoiced, and differentially enacted, and increased attention to the potential of therapy to liberate or oppress through the narratives they supported. Similarly, queer theory expanded thinking about inclusion by "unmasking the social practices that construct normality," blurring distinctions between socially constructed categories, and inviting previously unexamined possibilities regarding sex, gender, relationships, and family (Oswald, Kuvalanka, Blume, & Berkowitz, 2009, p. 43; see also Chapter 23 on queer couples, in this volume, by Coolhart).

SCAFT draws on all these legacies to apply an intersectional lens that attunes to how identities such as race, class, gender identity, gender expression, biological sex, sexual orientation, ethnicity, nation of origin, religion, age, and abilities all intertwine within hierarchies of power, privilege, and oppression to affect personal and relational experience and vulnerabilities (Almeida & Tubbs, 2020; Falicov, 2014). These include the effects of White supremacy and institutional privileging of Western or Eurocentric knowledge on intimate and family life, as well as consciousness that these interconnected aspects of relational life are inherently sociopolitical, as well as cultural.

Socio-Emotional Relationship Therapy

SERT was developed by Carmen Knudson-Martin, Douglas Huenergardt, and a team of colleagues who set out to learn how to address culture and societal power issues in couple therapy by systematically studying clinical processes in their own work and iteratively making changes to the clinical model, competencies, and sequence (Knudson-Martin & Huenergardt, 2010; Knudson-Martin, Huenergardt, et al., 2015; Knudson-Martin, Samman, & Wells, 2015). SERT was informed by prior feminist scholarship that called on therapists to address the gendered nature of destructive relationship patterns and the tendency of therapy to blame women for couple and family problems (Hare-Mustin, 1978; McGoldrick et al., 1989). These feminists raised attention to the destructive nature of power differences and advocated that partners should not automatically be treated as though they are equal (Walters, Carter, Papp, & Silverstein, 1988); that therapists need to be accountable for the values promoted by their models and their influence on equitable clinical outcomes (Goldner, 1985). As such, SERT was developed to center equity and attend to the nuances of intersecting social locations and felt identities through an inclusive, nonbinary contextual lens.

SERT begins with the premise that intimate relationships can and should mutually support each partner—an idea that clients from divergent sociocultural contexts readily embrace. The approach employs the interplay among social discourse, emotion, and couple interaction to connect what happens in the moment-to-moment of therapy with societal context and power. SERT also draws on advances in neurobiology and relationship research, which suggest that reciprocal emotional attunement based on equal power is critical to relational engagement and clinical change (Fosha, 2009; Knudson-Martin & Huenergardt, 2010).

SERT therapists position their work to counter the influence of dominant discourses associated with heteropatriarchy and Western models of self-reliance, achievement, and competition that work against relationality (Knudson-Martin, Kim, Gibbs, & Harmon, 2021). Though transforming gendered power is a substantial contribution of the SERT approach, the model applies beyond mixed-gender and/or dyadic partnerships and is consistent with viewpoints that emphasize flexibility, possibility, and evolution within cultures and nonbinary conceptualizations of sex and gender (Knudson-Martin, 2016).

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

When applying SCAFT practices, couple therapists orient their work to promote just relationships in which partners equitably share relational benefits and responsibilities within whatever other clinical model they use. They respect the sociocultural values and idiosyncratic perspectives of clients while concurrently confronting oppression and inequities. Therapists consider how the needs, interests, and well-being of each partner are reflected in relationship organization, decisions, and communication processes. When partners do not hold equal power to affect the other, more dominant partners' realities and interests shape relationship patterns and limit intimacy and the ability to flexibly respond to crises and life transitions (Knudson-Martin, 2013; Nicoleau, Choau, Kang, & Knudson-Martin, 2016). In healthy relationships, partners across cultural contexts are able to support each other in dealing with the effects and limits of societal injustices in their lives and enact third-order change based on a wider range of possibilities. Because power dynamics underlie other relational processes such as communication, conflict resolution, and intimacy, they are foundational to other clinical changes (Knudson-Martin, 2013).

Just Relationships across Cultures and Contexts

Societal inequities affect couple relationships in many ways. Social and economic capital provide and limit the kinds of resources and support available to partners, which may in turn shape both the likelihood of outside stressors and how couples respond to them. Systems of oppression and privilege at the societal level are reflected in how partners attune to each other, communicate, and resolve problems. For example, an affluent White male may unconsciously expect his Latino male partner who makes considerably less money to organize around his time available. Individual identities, feelings of self-worth, expectations regarding what one has a right to receive in a relationship, and notions of obligations and value to others are all socioculturally constructed and affect the flow and balance of power between partners and their ability to support each other (e.g., a wife may not directly raise her relational concerns to her husband because she is trying to resist internalized sociocultural assumptions about "nagging" women).

From a third-order perspective, emotion is a link to the societal. Emotions connect individual bodies and minds with relational and societal environments (Siegel, 2012), and include an almost instantaneous visceral read of the power context (Wetherell, 2012). Openness to attune to and take in another's perspective and expectations about what one is entitled to, responsible for, or judged by are responses to felt sociocultural experience, norms, and standards. For example, in a recent couple session, LaShawna expressed feeling disappointed and let down that although William was making efforts to spend more time with her and their daughter, he did not seem to "want" to be there. William responded angrily that he would never do anything he did not want to do. Their emotional responses reflected and reenacted "gendered individualism," a societal-based difference in who orients to and accommodates the other that accounts for much of the relational dissatisfaction in contemporary mixed-gender marriages (Loscocco & Walzer, 2013).

Whether a person assimilates or resists dominant societal constructions, these standards affect everyone who interacts with the dominant culture. Complex and nuanced responses to the multiple social locations one inhabits contribute to how partners experience themselves and each other, what they expect, and how they react. For example, Troy, a trans man, enacted masculine expectations that he was entitled to having his emotional needs met by his wife without realizing that he was not reciprocating. This was complexified by years in a marginalized social location in which people did not understand his experience. When he met Beth, she seemed to understand him in ways to which he was not accustomed. As a result of these intersecting identities, Beth did the emotional work for both of them.

Concepts of hierarchy and individuality also take on different meanings across cultures. Western ideas of communication and individualism emphasize give and take based on directly expressing one's needs and perspectives; social stratification and hierarchy embedded within Western societal norms tend to be masked, making power differences more covert and invisible to the persons involved (Silverstein, Bass, Tuttle, Knudson-Martin, & Huenergardt, 2006). Collectivist cultures care about individual well-being but place it within a sense of interdependence in which all family members are expected to orient responsibility toward the whole, hierarchies are overtly recognized, and intergenerational obligations are part of couple life; to preserve harmony, communication is less direct (Hofstede, 2001). Mutuality and respect for hierarchy and tradition may coexist.

Just Relationships across Clinical Models

Socioculturally attuned therapists help partners reflect on and redefine "normal" to construct a new vision of "healthy" based on an expanded awareness of the connections between personal and relational well-being and larger sociocultural power contexts. Table 12.1 illustrates how conceptualization of just relational possibilities varies depending on the clinical model through which SCAFT is applied.

Consider the case of Goldie (25) and Jim (24), a White, cisgender, mixed-gender, low-income couple with a 3-year-old son, Alex. They seek couple therapy for "communication problems." Goldie is 6 months sober and actively engaged in a 12-step program. She feels guilty, especially around the effects of her substance use on Alex and is grateful for Jim's support. They describe a history of "unfaithfulness" on both their parts, fighting, and emotional distance, and are worried because Alex is having behavioral problems at preschool. Working with the couple to create a vision of what would constitute health would be framed somewhat differently depending on the couple therapy model through which third-order thinking is applied.

Socioculturally attuned structural couple therapists would begin with a view that a healthy relationship structure for Jim and Goldie would support optimal development of each of them and their son. Support for Goldie's sobriety would be expanded to consider how societal gender norms and societal standards of success are part of their interactional patterns around her substance use and recovery, as well as how the couple manages emotional distance and closeness. For example, they might notice that Jim is able to engage when Goldie's issues are the focus but disengages when he is invited to be vulnerable—a relational pattern that maintains a stereotypically gendered power imbalance. They would likely help the couple move toward a relationship structure that did not depend on the female partner being in need of "help."

From an intergenerational perspective, socioculturally attuned therapists would help Goldie and Jim develop a just relationship based on differentiated selves that recognize substance use and infidelities as emotional reactivity to sociocultural contexts and family histories and encourage the couple to address conflicts directly. Healthy differentiation would be based on equitable power processes, for example, that Jim's ability to appear more differentiated does not depend on Goldie's or Alex's symptoms keeping the focus off him. Jim and Goldie would differentiate from societal models that leave him emotionally disengaged and put relational responsibility, parenting, and blame on Goldie.

A collaborative therapist informed by SCAFT would seek to create a dialogical relationship between Goldie and Jim that includes and values each partner's voice and creates space to imagine possibilities beyond taken-for-granted realities. Inequitable societal power processes, such as Jim's passivity regarding relational/parenting issues and the clinical focus primarily on what Goldie can change, are resisted so they do not limit what is discussed or envisioned as possible. The therapist would ensure that each partner take responsibility for and be able to influence the direction and outcomes of the conversation and invite the couple to develop a relationship model that works for them and overcomes the effects imposed by dominant societal discourses (e.g., low self-worth, feelings of incompetence, substance use, limited parenting and relational options).

The Circle of Care

Most contemporary couples tend to express egalitarian ideals, but do not have a vision of what a healthy egalitarian relationship might look like in practice (Mahoney & Knudson-Martin, 2009; Sullivan, 2005). SERT offers guidelines known as the Circle of Care (Figure 12.1), four conditions that promote a just, mutually supportive relationship: mutual vulnerability, mutual attunement, mutual influence, and shared relational responsibility. Rather than skills to be taught, they are orienting principles that look somewhat different depending on clients' sociocultural contexts, circumstances, and preferences. The Circle of Care is premised on shared participation of each partner in what Porges (2009) called the "social engagement system," in which the neural system of each partner mutually impacts emotional regulation and the physiological state of the other. This biobehavioral process enables a sense of emotional "fittedness" (i.e., feeling recognized by; Fosha, 2009, p. 179), through which partners experience mutual support that promotes healing, change, and transformation. This reciprocal process is only possible from equal power positions.

TABLE 12.1. Socioculturally Attuned Conceptualizations of Just Relationships

Systemic model	Just conceptualization of health	Sociocontextual considerations
Structural	Relationship structure supports optimal development for all partners.	How do cultural norms, access to social and economic resources, and power influence interaction patterns?
Strategic	Circular patterns in the relationship support equitable power processes.	How may symptoms be resistant to societal power imbalances? How may hypotheses maintain or intervene in societal power processes?
Experiential	Relationship supports growth by liberating selves from destructive sociopolitical messages and expectations.	How do societal power differences limit open expression? How may sociocultural attunement to felt experience support shared resilience?
Attachment	Relational connections empower partners to equitably support each other through life stresses.	How do societal gender/power processes affect emotion, expression of relational needs, development of relational bonds, and safety?
Intergenerational	Partners connect with family history and sociocultural contexts to build relationship and shared life choices from a differentiated sense of self.	How are personal biographies interwoven with societal relationships? How do societal power processes influence how differentiation is developed and expressed?
Contextual	Accountability and balance of fairness in current relationships transform the effect of past injustices and enable ethical future options.	How do past and current societal injustices affect the relational ethics, entitlement, and responsibility between partners?
Cognitive-behavioral	Awareness of contextual sources of thoughts and triggers enables relationship patterns that do not automatically follow societal norms and power structures.	How are personal and relationship schemas connected to societal schemas? Whose interests do internalized societal schemas represent? How are these replicated in relationship patterns?
Solution-focused	Partners choose and amplify solutions that expand possibilities for equitable, just relationships.	How are unique solutions to personal problems connected to shared public problems? How do solutions reflect powerful voices?
Collaborative	Dialogue includes and values each partner's voice and creates space to imagine possibilities beyond taken-for-granted realities.	How do societal power process shape and limit what is brought to the dialogue and whose interests are prioritized? What preferred ways of being are overlooked?
Narrative	Relationship stories center just alternatives to dominant societal discourses.	How are dominant societal narratives embedded in partner's stories? Who has the power to determine which stories get told? How are alternative stories silenced?

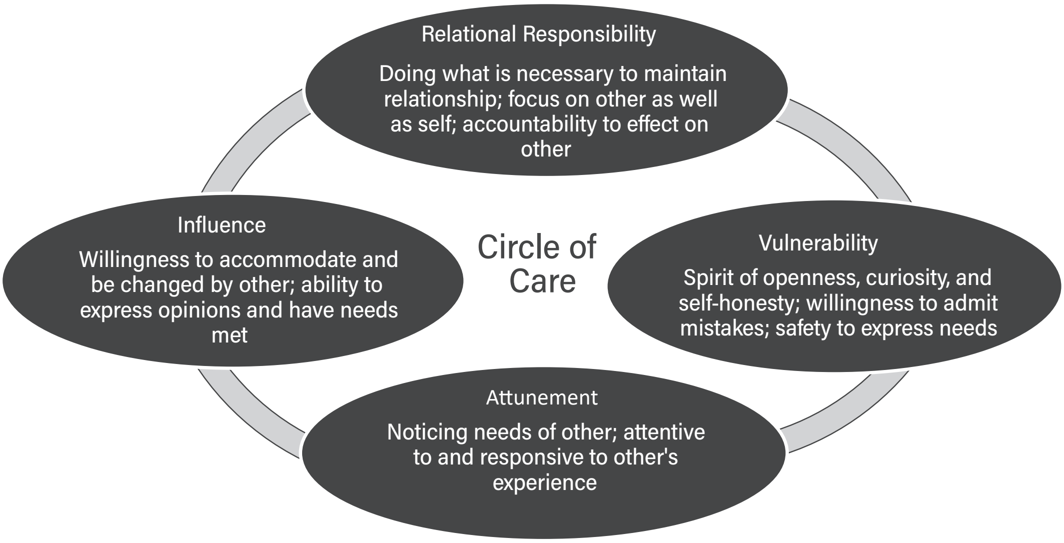

Relational Responsibility
Doing what is necessary to maintain relationship; focus on other as well as self; accountability to effect on other
Influence
Willingness to accommodate and be changed by other; ability to express opinions and have needs met
Circle of Care
Vulnerability
Spirit of openness, curiosity, and self-honesty; willingness to admit mistakes; safety to express needs
Attunement
Noticing needs of other; attentive to and responsive to other's experience

FIGURE 12.1. Circle of Care. From Knudson-Martin & Huenergardt (2015). Reprinted with permission from Springer.

Mutual Vulnerability

Mutual engagement requires participants to be emotionally present and available to each other. This requires mutual vulnerability in which each approaches the other with openness, curiosity, and willingness to admit mistakes and express needs. Distressed couples frequently demonstrate an imbalance in how partners demonstrate vulnerability. Though everyone experiences vulnerability, how it is expressed is shaped by cultural and gender socialization, as well as experiences of marginalization and trauma—all of which intersect with relational development (Knudson-Martin et al., 2021). When expressing vulnerability is socially prohibited or unsafe, the social engagement system is not able to be accessed. Gender norms generally invite women to express emotional vulnerability and discourage men from doing so.

Mutual Attunement

Among healthy couples, each partner attunes to the other (i.e., each notices and responds to the other's experience). The partners feel known. When a partner is not attuned, disruption of affect regulation and relatedness occurs; rather than the relationship being an energizing force for growth and change, the relationship may contribute to stress and symptoms such as depression and anxiety (Fosha, 2009). Emotional attunement and the ability to respond to emotion is influenced by heteropatriarchal gender socialization, and an orientation toward mutual attunement is not supported by Western discourses based on individuality and direct communication. While not negating the value of communicating needs and interests directly, mutual attunement emphasizes proactive awareness of another and responsiveness based on that recognition. Imbalances in emotional attunement are common among distressed couples, across gender identities and sexual orientations (Richards, Jonathan, & Kim, 2015).

Mutual Influence

In a just relationship, each partner is willing to accommodate and be changed by the other, and equally able to express opinions and have their needs met. In terms of the social engagement system, the neurons of one partner change in response to the other. Influence is thus more than shared decision making. It is an attitude of receptivity to input from the other. When power imbalances are present, less powerful partners are more likely to make changes in response to the other, oftentimes without the more powerful partners being aware that they are doing so. Changing to accommodate or be responsive to another contradicts models of masculinity that emphasize being right and taking charge.

Shared Relational Responsibility

In a just relationship, each partner also focuses on what is necessary to maintain the relationship and is attentive to the relational effect of their actions. This shared orientation toward the well-being of the relationship represents a shift of gender norms that place responsibility for tending to others' needs and relationships as a whole on women. Persons with less power are more likely to make efforts to preserve the relationship, often by doing the bulk of the emotional tending, calming, or looking out for the needs of the more powerful partners, and taking responsibility for the details of relationship maintenance that more powerful partners may not notice or care to deal.

THE PRACTICE OF SCAFT

The Structure of the Therapy Process

Regardless of the clinical model to which therapists apply socioculturally attuned principles, they begin with reflective awareness regarding the context of the treatment system itself. What values are represented? Who is the model designed to fit? Who determines what constitutes a problem? How do the location, hours, and cost limit who has access? Who is represented in the clinical space? Length of treatment, who to see in what constellations, use of diagnoses and psychotropic medications, kinds of assignments, and length of treatment are all considered through a third-order lens and their effects on equity and relational justice.

SCAFT looks beyond the immediate relationship to become aware of extended family, families of choice, friendship networks, and significant others, as well as the community context and involvement in other societal systems (legal, medical, educational, religious, etc.). Individuals or groups representing these constituencies could potentially be involved in therapy sessions and/or assignments, and therapists may decide to use their power to support partners in their dealings with larger systems. Community-based groups, such as Almeida's (Almeida & Tubbs, 2020) healing circles, help dissolve the distinctions between public and private relationship issues, help clients understand the effects of domination and subjugation in their lives, and promote accountability on the part of powerful partners.

In general, working with partners together makes subtle power processes in couple dynamics visible and accessible for clinical intervention. Decisions regarding whether and when to include individual sessions are made with awareness of their impact on enabling partners to relate more equitably. In this context, individual sessions may be used to screen when safety concerns are present and when personal exploration/accountability is important in service of the relationship. If more extensive individual work is recommended, it should always be integrated back into the couple's work. In the earlier example of Goldie and Jim, while Goldie may benefit from individual work processing sobriety and her evolving sense of competence and worth, such a move could easily reinforce the power dynamic that she is the one responsible for relational change if the therapist is not intentional regarding the relational purpose of the individual sessions. Individual or group sessions with Jim could help correct the power imbalance if they are directed toward helping him take responsibility for his contributions to the relationship. Similarly, psychotropic medications and diagnoses may be incorporated as part of socioculturally attuned treatment, if their use is framed in ways that do not perpetuate individualizing and medicalizing relational and sociopolitical problems by locating them within individuals and/or inhibiting client resourcefulness and action toward third-order change. For example, rather than organizing therapy around Goldie's recovery from a substance use disorder (how the couple originally described their situation), therapists applying SCAFT would help the couple explore alternative responses to larger societal patterns/messages that informed their responses to each other and substances.

How long treatment is needed depends on the many intersecting factors affecting a couple's relationship processes. Partners in newer relationships often relatively quickly correct power imbalances that interfere with their egalitarian ideals. Couples who have been in a relationship longer or who are dealing with substantial effects of societal and/or interpersonal trauma or relationship wounds may require extended therapy and could involve subsequent checkups when new stressors emerge (Wells et al., 2017).

The Role of the Therapist

Socioculturally attuned therapists believe that therapeutic leadership, balanced with a collaborative stance, is necessary so that dominant societal forces do not organize how relational problems are defined. They do not believe it is possible to be neutral; thus, they think it is necessary to facilitate partners' awareness of the systems of systems at work in their lives. Therapists orient their roles according to six guiding principles that can be applied within all couple therapy models.

ANVIET Principles

SCAFT guiding principles are represented by the acronym ANVIET (McDowell et al., 2018, p. 24):

- *Attune*: Understand, resonate with, and respond to experience within societal contexts.
- *Name:* Identify what is unjust or has been overlooked—amplify silent voices.
- *Value*: Acknowledge the worth of that which has been minimized or devalued.
- *Intervene*: Support relational equality—disrupt oppressive power dynamics.
- *Envision*: Provide space to imagine just relational alternatives.
- *Transform*: Collaborate to make what is imagined real—third-order change.

Applying ANVIET involves moment-by-moment clinical decision making based on third-order ethics in which therapists take responsibility for positioning their work to counteract, interrupt, and transform the workings of societal-based inequities in couple relationships. This stance is important from the beginning of therapy, as it determines how presenting issues will be framed and the goals and interventions that follow.

In the case of Goldie and Jim, therapists *attune* to Goldie's sociocultural experience around her substance use and how these connect to her identity as wife and mother. For example, how her sense of guilt is connected to societal constructions around "a good mother," such that when their son Alex misbehaves at school, these societal messages tell her (and others, including Jim) that she is at fault. They apprehend how substance use may be a way for Goldie to cope with messages that she is responsible for what men do to her body. They attune to how Jim's sense of his worth is tied to his economic status and accomplishment, and how the couple's relational patterns reflect and reinforce these social identities and power processes.

SCAFT therapists are intentional regarding how they *name* the couple's issues so as not to reinforce societal constructs that promote inequality, such as that as a woman Goldie carries more responsibility for making the relationship work than Jim. They name the inequities these sociocultural patterns create in who carries the relational burden in the family and how they hold Jim back from engaging with his wife and child. SCAFT therapists reflect on what their words and actions *value* and ensure that these support relational qualities and intentions not validated by the dominant culture. For example, they may credit the caring work Goldie does and identify and highlight Jim's need for relationships and desire to connect.

SCAFT therapists see it as their role to *intervene* in oppressive power dynamics when they are present in the session. In this case, they intervene in the pattern that keeps Goldie more vulnerable and responsible than Jim, taking care that their interventions do not have the effect of putting more blame and responsibility on her and actively working to engage Jim in resisting the socialized pull to step back from relational responsibility. Interventions also counteract societal messages that the couple's problems are the result of their poor judgments or motivations, and instead encourage the couple to see the systems they are up against. They will also see it as their role to help the couple *envision* possibilities beyond the standards and expectations of the dominant culture and use their position to help *transform* the effect of societal inequities in the couple's life as they create new relational options reflective of third-order change.

The Therapeutic Alliance

Socioculturally attuned therapists and partners form an alliance to resist the effects of social domination and create just relationships. This involves simultaneously (1) developing and maintaining sociocultural attunement to each partner and (2) positioning the therapeutic stance to counteract power imbalances. Attunement without positioning therapist actions in relation to power is likely to reinforce the existing power imbalance. For example, gender and class socialization could be used to explain Jim's distance in the relationship and make it more palatable to Goldie, reinforcing the relational burden on her. On the other hand, if therapists attempt to correct the power imbalance without first socioculturally attuning to Jim, he is likely to feel incompetent, blamed, and attacked.

Research on successful application of the SERT model highlights the importance of attention to the intersections of power, vulnerability, and societal context when forming a working therapeutic alliance (Knudson-Martin et al., 2021; Wells et al., 2017). Conversation that brings the lived sociocultural experience of each partner to light minimizes individual blame and encourages a "we are confronting this together" attitude. Less powerful partners are more able to trust because their experience is named and validated, while more powerful partners are able to engage without feeling misconstrued or judged. Therapists are careful to avoid colluding with cisgender and heteronormative stereotypes or intentionally or unintentionally aligning with male partners (who are also likely to be more powerful), a situation that Anderson and Johnson (2010) found to increase female psychological symptoms.

Active, Responsive Leadership

Socioculturally attuned practice requires active leadership that orients therapy through a third-order lens, which also enables staying attuned to clients' sociocultural experience and being responsive to their input. For example, when Jim responded to questions about how he envisioned his role as an engaged father by saying that he needed to support Goldie in her sobriety, the therapist responded, "You see your primary role as supporting Goldie so she can be a good mother to Alex." But the therapist did not stop there and also provided leadership in directing Jim back to a third-order lens on his parenting: "And, when you think about what could be possible as a father, how would you like to see yourself more directly involved as a parent?" When Jim drew a blank, the therapist responsively persisted (e.g., Sutherland, Turner, & Denhart, 2013): "It's hard to see yourself mattering that much as a father. What do you wish you had to offer . . . beyond a paycheck and supporting Goldie?"

When and how therapists encourage partners to engage directly may vary depending on which model of couple therapy is applied with a socioculturally attuned approach. SERT therapists promote partner engagement; however, in early sessions, therapists may need to intervene frequently to address power dynamics and create and maintain focus. Most therapists who integrate a social justice lens into their practice are transparent about their clinical lens, how they use their clinical power, and why they are introducing a topic into conversation (D'Arrigo-Patrick, Hoff, Knudson-Martin, & Tuttle, 2017). They would tell Goldie and Jim that they work from the premise that relationships should mutually support each partner and ask if they agree. They may also promise to interrupt when they see the couple getting off track or missing something (e.g., "I see a lot of fathers not as engaged in parenting as they want to be, I usually step in when I see this happening. Is that okay with you?") Therapists may also share some of their internal experience or impressions: "Jim, I see you shut down when our conversation turns to parenting—I feel sad because I know you want to be there and I wonder what holds you back?"

Assessment and Treatment Planning

SCAFT and SERT operate from key assumptions about assessment and treatment planning: (1) They assume these processes are ethical sociopolitical issues that demand self-awareness, critical thought, and reflexivity (McDowell, et al., 2018); (2) they assume these processes are interactive, reflective, collaborative, and ongoing; and (3) that they must be explored in the context of clients' unique niche in the sociocultural context (Falicov, 2014) in order to facilitate awareness of the nuanced power processes involved, develop connections between personal experiences and larger social systems, and envision possibilities.

Assessment and treatment planning must be done from a place of both "knowing and not-knowing" (Falicov, 2014, p. 42). We need to be informed regarding how larger societal systems work and also seek to understand each couple's unique experience without stereotyping or assuming that cultures and contexts are fixed. For example, Falicov's (2014) multidimensional ecological comparative approach (MECA) assesses four domains that personalize experience within social justice and cultural diversity: ecological context, migration/acculturation, family life cycle, and family organization. MECA assessment explores how these intersecting sociocultural/sociopolitical contexts influence meaning and experience over time.

Complexities and tensions are inherent. For example, how do we differentiate between what is typical in a culture and what is common but also subjugating or unjust? How do we help partners examine taken-for-granted cultural practices and expectations that are not just? What social constraints do clients face that may limit their agency? How may one person's agency be at the expense of another's? What are the potential costs of resisting injustice? Therapists should avoid seeing these tensions as dichotomous and instead help clients explore competing values or choices and identify relational possibilities that may previously have been hidden or not accessible.

SCAFT Assessment Framework

SCAFT therapists integrate assessment of sociocultural context and a power analysis into their preferred clinical model. McDowell and colleagues (2018) illustrated applications for 10 major models. Examples of assessment questions relevant across models are suggested below.

- *Attune*. What is it like for each partner to live as a [insert social locations] in this world? What societal messages have partners received about what it means to be successful or about their worth/value? How might your own social location and/or dominant culture expectations as the therapist influence what feels appropriate/good to you in this case?
- *Name*. What societal inequities have the clients experienced? Which of their skills or qualities are likely to be discredited or overlooked in the dominant discourse? How are these connected to clinical concerns?
- *Value*. What societally overlooked relational values and characteristics may clients endorse when space is created for them? How can you validate the worth of what has been minimized or devalued in their lives?
- *Intervene*. What power dynamics are present in the processes between partners? Who has more influence on the other? Whose interests shape the relationship? Is one person's well-being at the expense of another's? How may your internal responses to societal power dynamics interfere with your ability as therapist to intervene in oppressive power dynamics?
- *Envision*. How may clients' preferred values support more just relationships? What will the treatment plan look like when guided by these alternatives?
- *Transform*. What enables clients to maintain focus on their just relational goals? How can you support this process while taking into account complexities regarding cultural values, societal limits to autonomy, and potential costs of resistance?

SERT Assessment and Treatment Planning

SERT therapists interpret assessment data through the wider societal lens and concurrent context of the Circle of Care. The assessment process sets the stage for partners to see themselves and their relationship through an expanded contextual lens and to begin to consider what mutuality might look like for them. A typical first session includes questions about the presenting problem and an overview of their social and family contexts. The therapist shares that work is done from an expectation that relationships should mutually support each partner and asks if that fits for them. Throughout the conversation, the therapist tracks power processes demonstrated through which partner reports what, how it is reported, and how partners respond to each other's report, and assesses how the couple currently enacts the Circle of Care. The therapist forms an impression of sociocultural identities and vulnerabilities and begins to link the personal and contextual, with special attention to highlighting relational aspirations, values, and resources, as well as each partner's openness to work within the Circle of Care. Commitment to overt dominance, aggression, or violence, and/or disregard or unwillingness to express relational accountability or values is contraindicated.

ASSESSING FLOW OF POWER AND MUTUALITY

Because mutuality in the Circle of Care depends on a relatively equal flow of power, assessing them is intertwined. Therapists track flow of power and mutuality as the couple talks about their relationship and observe subtleties in how power presents. The example of Ana and Gillian illustrates this process.

Imagine you are the therapist. The intake form indicates that Ana (age 34) identifies as Latina and Gillian (age 29) as White. They have been together for 9 years and married for 5. Both indicate they are pansexual. Gillian works as a technical assistant in an advertising company, and Ana works part time as an aide in a group home. Ana lists epilepsy as a medical condition and is unable to drive. Each also notes multiple mental health disorders, including posttraumatic stress disorder (PTSD), depression, and anxiety. They report childhood traumas and no physical aggression in the current relationship. Trust is their primary concern, although the couple did not report any history of infidelity.

When you ask what prompted them to seek couple therapy at this time, Gillian animatedly reports that she moved out for a while because she discovered Ana had responded to a message on social media from a high school boyfriend, Ramil, and she can't trust her. Ana meekly explains that she simply returned a casual message she had received and did not realize this would be so upsetting to Gillian. When Gillian insists that Ana should not have done this, Ana quickly agrees, stating that she knows this is hard for Gillian and will do whatever it takes to gain her trust again. As you explore the meaning each partner makes of this event, you learn that neither partner is concerned that Ana and Ramil will regularly get together or have an affair. You notice that Gillian is defining the problem and what constitutes a breach of trust, and Ana seems to readily accommodate Gillian and acknowledge her perspective.

To continue tracking this power dynamic, you ask Gillian, "Ana says she is willing to do whatever it takes to build your trust. What makes *you* willing to work on repairing the bond between the two of you?" Gillian's response, "She doesn't need to be in contact with him," tells you that she expects to define parameters for Ana's contact with Ramil and that responsibility for relationship repair currently seems one-sided. You continue to track this observation regarding power and mutuality by seeking to clarify this emerging hypothesis: "Ana, Gillian is pretty clear about setting terms for your relationship with Ramil. What makes you willing to go along with that?" Ana explains that she understands this is important to Gillian and that Gillian can monitor her social media as much as she needs. In the meantime, Gillian continues to show little interest in Ana's perspective, suggesting an imbalance in the flow of power that limits mutuality in the Circle of Care.

You name the power imbalance and expand your inquiry to assess whether this power imbalance extends beyond this particular incident. "Is this usual—that Ana is the one who puts in more effort to keep the relationship going? Or does it switch back and forth?" This causes the couple to pause for a bit. They are not used to considering the flow of power. The question also makes your value orientation toward mutuality explicit. Gillian responds that Ana is "a caregiver." Ana reads this as a negative attribution, and agrees, and says she's "trying to work on that." Their responses suggest a more pervasive power imbalance in which Ana carries the bulk of the relationship load. To understand this pattern, you move toward the sociocultural discourses and felt identities embedded within their stories.

ASSESSING SOCIETAL DISCOURSES AND FELT IDENTITIES

In order to make sense of partner power dynamics, we have to consider how what we see is influenced by the societal discourses that shape clients' felt identities and dominant discourse messages about relationships. In SERT, giving care is valued and integral to relationships. Yet we recognize that it is devalued in dominant Western discourses. Both Gillian and Ana also seem to minimize it or see it as a negative. To learn what this means to them, you open "caregiver" as an area for exploration and potential relational resource that has been discredited.

THERAPIST: (*to Ana*) What does it mean to you to be a caregiver?

ANA: That I take care of people—look out for their needs. I'm trying to do less of that. (*Smiles, then sighs.*) It's just who I am.

Your assessment goes toward the sociocultural nature of Ana's felt identity: "I'm curious what messages you've gotten from others about being a caregiver." You learn that Ana has absorbed societal ideas that healthy or competent persons look out for themselves; that she should not give so much of herself. Gillian also endorses the idea that caregiving is problematic, especially when Ana extends it to family and friends: "People take advantage of Ana." Ana says overcoming her tendency to "care give" has been part of her prior therapy, which you recognize as a way mental health providers may perpetuate discourses favoring individualism. You wonder how open Gillian and Ana may be to an alternative discourse around caregiving: "Are there ways that you see giving care as an important part of relationships?"

You also suggest that understanding their backgrounds is important and ask about each partner's family and social contexts. You ask questions, for example, (to Ana) "So you grew up with a single mother. Was that similar for other people at your school or different? What was that like for you?" You continue to integrate this sociocultural inquiry in subsequent sessions, always seeking to apprehend the connections between the relationship issues present in the room and each partner's felt experience in the larger social world, which includes intersections around gender, sexuality, race, ethnicity, socioeconomic status, mental and physical health, and legal statuses. As they discuss their histories and contexts, you notice that neither partner seems comfortable or able to express vulnerability, and you are curious to attune to the sociocultural nature of their vulnerabilities (Knudson-Martin et al., 2021).

RELATIONAL STRENGTHS AND RESOURCES

By drawing attention to mutuality patterns and discourses/values around caregiving, the assessment process is beginning to define the relational/sociocultural framework for the therapy. You identify relational strengths and resources, such as Ana's orientation to give care, that dominant societal discourses fail to appreciate or pathologize. To see how readily the more powerful partner, Gillian, can identify her relational interests and values, you ask, "How does Ana make your life better? What about your relationship with her do you need and value?" The couple describe being able to talk about most things and say they were drawn together because they understand each other's mental health diagnoses. You conclude that the couple has many relational strengths and share this observation with the couple as you move toward preliminary goal setting.

If there were indicators of power inequities that might make conjoint therapy risky or an affair in which emotions are highly charged, you would ask to see each partner individually to determine whether and how to continue with direct couple work. If initial screening or early impressions suggest that seeing the couple together may not be safe, you would move to individual sessions first.

Goal Setting

The overarching goal in socioculturally attuned therapy is third-order change that promotes just relationships and empowered responses to societal inequities and stresses. Since most contemporary couples espouse egalitarian ideals but do not have a model of what such a relationship would look like (Mahoney & Knudson-Martin, 2009; Sullivan, 2005), goal setting requires collaborative but active leadership in envisioning possibilities. Goal setting is an opportunity to engage clients in clinical work that expands their orienting discourses. It helps set the stage for partners to be intentional about their responses to otherwise taken-for-granted societal patterns/discourses. How goals are framed will depend on the therapist's theory of change (see Table 12.1). Examples include the following:

- Partners develop communication patterns that respect and value each partner's voice.
- Partners liberate themselves from destructive sociopolitical messages and expectations.
- Partners build relationship bonds that enable them to mutually support each other through life's stresses.
- Partners develop trust through a balance of fairness and accountability.
- Partners create new stories for mutual support that overcome taken-for-granted realities.

In SERT, goal setting is a mutual, co-created process between therapist and couple. The therapist uses questions that transparently introduce the Circle of Care framework and help partners explore consequences/meanings/implications of their goals. In the case of Gillian and Ana, given their initial goals around trust, and first-session assessment of power, mutuality, and relational resources described earlier, you move toward a beginning goal by saying:

> "I'm impressed with the commitment to a mutual relationship based on trust that each of you say you are seeking. A number of things seem to be getting in the way of the kind of back-and-forth engagement you pictured when you first got together. I'm guessing that a lot of these are connected to what you've experienced outside your relationship, learned from the world in which you and your families live. We started to talk about a few today: messages about what it means to give care or to have a mental illness, what we have a right to expect from another in a relationship and who decides, and how safe it is to express vulnerability. One way our work together could be helpful is to explore these messages and develop some that work better for you. How would this fit for you?"

Since these topics have already been raised in session, you are not surprised that both partners respond with readiness; however, you take the time to make sure what may resonate or not with each person: "What about this goal, this starting place, works for you?"

Through dialogue about the clinical focus and goals, partners are able to own and expand on what is meaningful to them. You look for and explore hesitations and/or differences between the partners and invite additional ideas, so that each partner has affirmed the goal of mutual support in a way that fits for her. You also promise to step in when you see mutual support getting off track. In subsequent sessions you and the couple will clarify more specific goals around mutual vulnerability, mutual attunement, and shared relational responsibility as a foundation for trust.

In cases where shared interest in maintaining an intimate relationship is less clear or other goals such as co-parenting or dealing with depression are primary, addressing the power dynamic is still an important lever for change, but goals may be framed somewhat differently. For example, in the case of a couple in which at least one partner is trying to decide whether to leave the relationship, a goal may be to develop a framework for understanding how this relationship got off track and what a mutually supportive future relationship would look like. In the case of co-parents, a goal may be to equitably share responsibility for co-parenting in a way that supports the well-being of the children and each other.

Process and Technical Aspects of Couple Therapy

SERT draws on strategies from multiple systemic models, including social-constructionist/narrative, attachment, structural, and contextual concepts and practices. The work involves helping partners mutually engage in the Circle of Care, so they can address their relational issues from an equitable foundation. The aim is to experience something new together, then consolidate that change or, as narrative therapists would say, "thicken the story." The three-phase clinical sequence illustrated in Figure 12.2 guides the work and integrates readily with other models.

Phase 1: Positioning

Phase 1 includes three interconnected processes that can be initiated in any order. Together, they bring the felt effect of societal discourses and power inequities into focus and position the therapy to support relational values. These include (1) attune to sociocultural emotion, (2) expose relational consequence of power inequities, and (3) explore sociocultural discourses. While SERT therapists may integrate moments of psychosocial education, we find that trying to teach clients about just relationships without first attun-

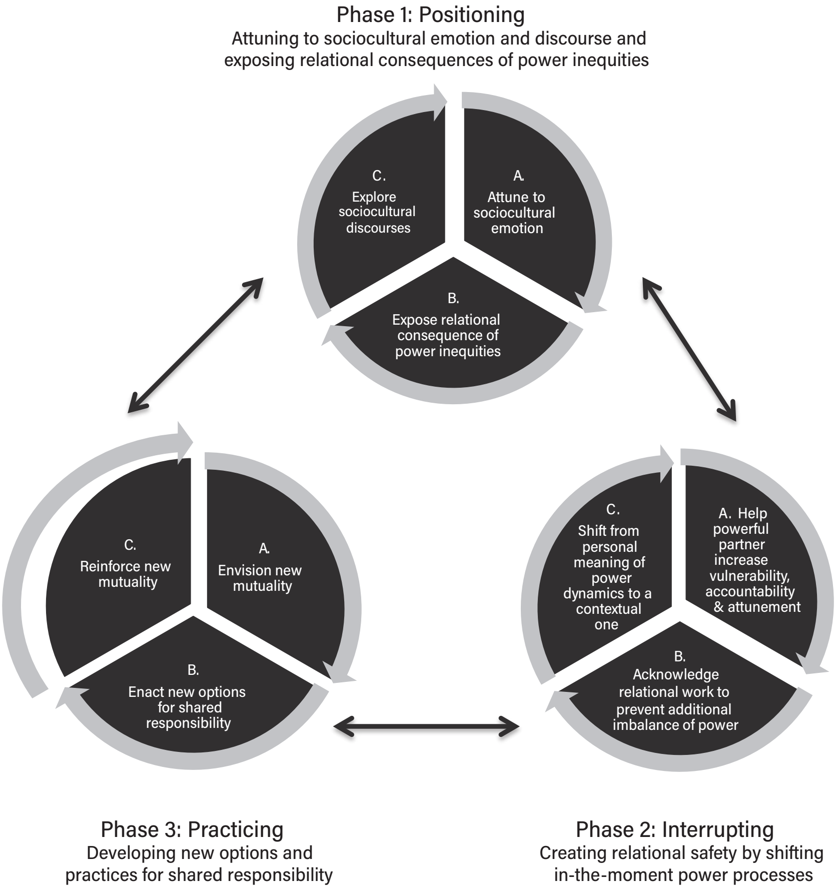

Phase 1: Positioning
Attuning to sociocultural emotion and discourse and exposing relational consequences of power inequities
A. Attune to sociocultural emotion
B. Expose relational consequence of power inequities
C. Explore sociocultural discourses
A. Help powerful partner increase vulnerability, accountability & attunement
B. Acknowledge relational work to prevent additional imbalance of power
C. Shift from personal meaning of power dynamics to a contextual one
A. Envision new mutuality
B. Enact new options for shared responsibility
C. Reinforce new mutuality
Phase 3: Practicing
Developing new options and practices for shared responsibility
Phase 2: Interrupting
Creating relational safety by shifting in-the-moment power processes

FIGURE 12.2. SERT clinical sequence.

ing to their sociocultural experience is not likely to work. By focusing on felt experience, abstract concepts relating to societal context and power become personal, and partners are invited into the social engagement system with each other and the therapist (Porges, 2009).

ATTUNEMENT TO SOCIOCULTURAL EMOTION

Attunement means that we therapists interpret what clients present through our understanding of their felt sociocultural experience and translate that into therapeutic questions to check for resonance (Pandit, Kang, Chen, Knudson-Martin, & Huenergardt, 2014). In the case of Ana and Gillian, both had experienced marginalizing social contexts that affect how they express vulnerability. As a large-bodied girl of color from a low-income household, who also had to deal with the possibility of epileptic seizures and internalized societal shame about her sexuality, Ana was frequently bullied in the nearly all-White school that she attended on scholarship. Attunement to sociocultural emotion involves seeking to apprehend and take in how all of these social identities come together in Ana's felt experience and, so much as it is possible, resonate on a visceral level. For example,

ANA: I tried not to let the teasing bother me, to smile, be nice . . . it was easier that way.

THERAPIST: I'm trying to take in what it was like to be in that school, feeling so different . . . targeted for being you. So alone.

ANA: (*Sighs.*) It was hard. Yeah. (*Nods.*) But I could almost always make people come around . . . keep the peace.

THERAPIST: If you put in the effort, if you didn't let the hurt get you down, you would be okay? People would accept you?

ANA: I don't know about "accept" me, but, yeah, if I could keep the peace, people would just ignore me and let me be. That made things better.

THERAPIST: If you could act like everything was okay instead of being the outcast, you'd be okay.

ANA: And others would not see it and worry too.

Ongoing attunement to sociocultural emotion frames relational patterns contextually. Ana was aware of how hard her single mother worked so that the family could survive, so she never "bothered" her mother about anything that affected her—from the bullying at school to even when her uncle molested her. Ramil, her high school boyfriend, who was also a person of color with medical issues, understood:

ANA: We had that in common . . . he understood some things.

THERAPIST: He understood how hard it is to be a student of color in a White school? And did he get the stigma around epilepsy too?

ANA: Yeah. It wasn't all good, that relationship, but that part is something I'll always carry with me.

Sociocultural attunement to emotion gives contextual meaning to vulnerability and social engagement processes, such as Ana as "caregiver" and what Ramil means to her. You "get" that not expressing vulnerable feelings was keeping her mother in mind and not possible due to Ana's marginalized social world. Similarly, you attune to Gillian's sociocultural experience and become aware of how mightily she felt "looked down on" at school for being "poor," for having a disabled mother and a father in and out of jail.

THERAPIST: You were a reject . . . untouchable. (*Gillian agrees.*) Who understood?

GILLIAN: A teacher sometimes, but then they left you. I had to depend on myself. I still do!

Gillian's response to her sociocultural context meant she never risked a romantic relationship until she met Ana, "I didn't even think about that . . . I just kept to myself."

EXPOSE RELATIONAL CONSEQUENCES OF POWER DIFFERENCES

This aspect of Phase I is critical because it connects observed power differences, such as imbalances in who attends to whom and who is open to influence, to the couple's relational goals and interests. Our research has shown that to relationally engage, powerful partners must first be connected to the relational consequences of their responses (Samman & Knudson-Martin, 2015).

> "You've both experienced marginalization, but your responses were very different. Gillian, you learned to depend on yourself, that you could not trust others to be there for you. [Gillian agrees.] So, you've also not learned how to take the steps to build relationship. [Turns toward Ana.] Ana, you learned to do the work

> of building relationships—not to expect others will do it. [Ana nods.] Now, in your marriage, Ana still does most of the work to keep the relationship going. But this really limits the back and forth between the two of you and puts a lot of weight on Ana. It seems the relationship ball is in your court, Gillian. Is a relationship where it falls on Ana to cement the trust for both of you what you want going forward?"

This intervention challenges the power dynamic, which is likely to catch more powerful partners a little off-guard. It is thus important to frame the power dynamic socioculturally, validate their relational goals, and help them take responsibility for the consequences of the current power imbalance.

> "It makes sense that you never learned the skills for repairing and maintaining a close relationship. [*Gillian agrees.*] It's also clear how important Ana is to you, how much you want her in your life. [*Gillian nods.*] How do you think it affects Ana and the relationship when you hold yourself back?"

Sociocultural attunement to vulnerability and interventions that guide more powerful partners toward their relational interests and accountability for the consequences of their part in the relationship imbalance will likely need to be repeated regularly in Phases 1 and 2 as power imbalances reassert themselves (Knudson-Martin et al., 2021; Samman & Knudson-Martin, 2015). In this case, as a first step toward relational engagement and accountability, Gillian moves back to the home she shares with Ana.

EXPLORE SOCIOCULTURAL DISCOURSES

Socioculturally attuned therapists notice societal discourses as partners tell their stories and respond to each other in session. The most relevant relate to messages about how they should enact their roles and identities, what it means to be a good person, and expectations about independence/togetherness, marriage, love, family, work, and success, and so forth. Therapists use these as points to expand the clinical lens outward. Therapists also seek to uncover the sociocultural discourses underlying emotion. For example, when Gillian responds that it is hard for her to even talk about *"him"* (referring to Ramil), you are curious about the sociocultural discourse that gives rise to this emotion:

THERAPIST: (*soft, questioning tone*) Something about Ramil is very important to you?

GILLIAN: (*emphatically*) He's her first love!

It is helpful to stay close to the client's experience as you seek to resonate with her contextual experience, then use questions that invite reflection about connections to the larger social world.

THERAPIST: What does it mean to you that he's her first love?

GILLIAN: I can never be her first love!

THERAPIST: The idea of first love is very meaningful to you. What do people say about first love?

This questioning begins to expand the lens to societal ideas around romance. Gillian has absorbed many cultural ideas around love as all encompassing, forsaking all others. It is important for the therapist to connect the dots between this discourse and Gillian's experience in the relationship while also zooming out: "[*nodding*] You've learned that no other love can be as powerful as first love. [*Gillian nods.*] And you wish you could hold that spot in Ana's life. Do you have a sense of where you got the idea that first love is irreplaceable?"

Expanding the lens provides clients a new way to think about their conflict. The conversation turns to movies, books, things Gillian hears people say. It is now possible to connect her loss at never being able to be Ana's first love (as Ana is for her) to the social meanings that inform this loss. These Phase 1 conversations establish an equitable foundation and focus for the therapy that enables partners to begin to see themselves and their relationship socioculturally, which makes alternative possibilities more accessible.

Phase 2: Interrupting

In Phase 2, the therapist emphasizes clinical interventions that shift in-the-moment power processes as the partners address their concerns. This interrupts the flow of power and creates relational safety. Three elements are involved: (1) help the powerful partner increase vulnerability, accountability, and attunement; (2) acknowledge relational work to prevent additional imbalance of power; and (3) shift from a personal meaning of power dynamics to a contextual one. The key is to take the power imbalance into account when deciding how to direct interventions that promote relational engagement, which often means the therapist does not ask the same of each partner. These interventions work best when they arise out of the in-session process.

HELP POWERFUL PARTNER INCREASE VULNERABILITY, ACCOUNTABILITY, AND ATTUNEMENT

A major part of the work in Phase 2 is helping the more powerful partner take responsibility for relational engagement. Before asking partners already in the most vulnerable or overloaded positions to express vulnerability or attune to their partners, it is important to ask and support those maintaining more powerful positions to take these actions. Rather than asking Ana (who already carries the bulk of relational responsibility) to share her fears or to attune to Gillian's fear, a SERT approach would first invite Gillian to express her vulnerabilities or encourage her to attune to Ana. This interrupts the usual flow of power and challenges the status quo. It may be met with "resistance" enacted as statements of helplessness or half-hearted attempts. Interrupting the flow of power requires therapists to responsively persist, to be encouraging and supportive while holding powerful partners accountable to engage.

For example, when you ask Gillian what it is like for Ana to so frequently take the responsibility for engaging her in the relationship, Gillian first responds, "I don't know—she doesn't tell me." It could be easy to then ask Ana why she doesn't speak up, or to recommend that she speak up, which would inadvertently put responsibility for engagement on the one already carrying more of the relationship load. Instead, you encourage Gillian to stay with the attempt to attune: "You know Ana. What do you think it would be like for her?" With support that also fosters relational accountability, Gillian will, perhaps slowly, begin to express awareness that Ana's attempts to engage her probably take a lot of energy and/or that Ana may put herself last. Instead of placing the primary responsibility on Ana to speak up for herself more or expect more of others, socioculturally attuned therapists ask themselves, "In what context would it make sense for Ana not to speak or expect much from her partner?" Later, Ana *will* be invited to express her thoughts and feelings, but it is important to first create a context in which she is likely to be heard.

In mixed-gender relationships the clinical action is likely to be similar, supporting men who hold power and have not learned relational habits to develop this part of themselves and risk responsibility for engagement. It is also important to take the history of the power dynamics of the relationship into account. Persons holding less power, and who previously carried the relational energy, frequently enter therapy angry or hurt and may appear disengaged. Or they may have had an affair (Williams, Galick, Knudson-Martin, & Huenergardt, 2013). When the onus is put on the powerful person to do relationship work, with persistence and time these less powerful disengaged partners often reengage.

ACKNOWLEDGE RELATIONAL WORK

Unequal power dynamics persist in large part because the contributions of the less powerful are minimized or overlooked. Thus, it is important to acknowledge and expand on the value of the relational work being done by the partner carrying this load. For example, imagine that Gillian describes an incident in which she was upset and anxious when she came home from work, so that all she could do was go to her room and lie down. A clinical response directed toward interrupting the relational power imbalance would focus on increasing Gillian's awareness of the work Ana is doing and might ask her to consider how Ana's presence helped her in that moment.

THERAPIST: (*to Gillian*) It sounds like you really needed to decompress from all that stress. (*Gillian agrees.*) How did Ana's being there help you with that?

GILLIAN: Well . . . she left me alone, she didn't push me to talk.

THERAPIST: She didn't push you to talk. How was that helpful for you?

GILLIAN: I didn't feel pressure. I knew she was there, but I could relax.

THERAPIST: (*to Ana*) Gillian says it was helpful that you didn't push her to talk. How did you know that was what Gillian needed?

ANA: I've learned that Gillian just needs some time. A little while later, I came to her and asked about her day. She was ready to talk then. I think our talk helped.

THERAPIST: (*to Gillian*) It sounds like Ana was very attentive to what you needed. (*Gillian nods.*) What did you especially appreciate about what she did?

GILLIAN: She helped me get out of my funk. I would have stayed there all night!

THERAPIST: (*to Gillian*) You're grateful for Ana's sensitivity to your needs and willingness to engage you. (*Gillian nods.*) Can you tell her that?

SHIFT FROM PERSONAL TO CONTEXTUAL MEANING OF POWER

Our research shows that successful efforts to shift the power dynamic by relationally engaging powerful partners are most successful when the power dynamic is connected to the sociocultural vulnerability each partner experiences (Knudson-Martin et al., 2021). In the case of Ana and Gillian, the therapist has begun the process of sociocultural attunement to vulnerabilities around each partner's experiences of marginalization. It is helpful to now bring that awareness back into the conversation:

> "[to Gillian] With all the ways people looked down on you in the past, for being different, for being poor . . . you said you learned not to trust anyone to be there for you. How was it for you to tell Ana just now that you appreciated her for being there, for knowing how to engage you?"

This conversation can then also continue to hold Gillian accountable for taking responsibility for taking a more vulnerable and active role in relational responsibility.

Phase 3: Practicing

In the final phase of therapy, partners develop new options and practices for shared responsibility. They now have a more equitable foundation from which to delve into difficult issues. Three clinical processes are involved: (1) envision a new mutuality, (2) enact new options and practices for shared responsibilities, and (3) reinforce new mutuality. As partners are increasingly able to mutually engage, the therapist serves as coach or facilitator, bringing partners back to their goals and helping them when they begin to fall back into old patterns. Techniques from many different clinical models may be incorporated.

ENVISION A NEW MUTUALITY

From the beginning, the SERT therapist has been helping clients envision and articulate goals related to mutuality in the Circle of Care. In Phase 3, therapists help clients detail these more fully. Narrative and solution-focused questions can be especially useful in helping clients create a more concrete picture of their aspirations and what is involved when their efforts to enact these are successful. (See also Chapter 10, "Narrative Couple Therapy," by Freedman & Combs, and Chapter 11, "Solution-Focused Couple Therapy," by Franklin, Zhang, Bolton, & Yates, both in this volume.) For Ana and Gillian, this includes helping Gillian see herself as able to take relational initiative. For Ana, it includes a picture of a relationship in which she is safe enough to also express needs or disagree with Gillian. Together, they are internalizing a personalized picture of mutual care.

ENACT NEW OPTIONS AND PRACTICES FOR SHARED RESPONSIBILITIES

Partners need practice engaging with each other through their evolving mutuality. The therapist continues to focus on the process between them, helping them orient to each other through the Circle of Care principles. When they get off track, the therapist helps them notice and process what happened, with an eye toward what works. For example, when you notice that Ana seems to be giving in quickly when discussing a conflict, you stop the couple and ask, "I'm wondering what's happening right now. Ana, are you feeling safe to express your thoughts?" You and the couple then track what happened for each. You ask Gillian if she noticed that Ana seemed to be holding back and encourage her to reflect on what she has learned to do to engage Ana. Then you invite them to try the conversation again.

REINFORCE NEW MUTUALITY

Efforts to transform societal-based patterns need reinforcement. The therapist does this by recognizing when partners demonstrate mutuality, highlighting what they did to accomplish this, and exploring the effect of these changes on their relationships. For example, when Ana is describing her worries about her cousin, you note that she says in passing that Gillian drove her to visit her cousin. Since Ana has typically had to take the bus to visit her extended family, you stop the conversation to highlight that Gillian did this and explore how that happened. Gillian's response showed that she is beginning to internalize the Circle of Care by making what matters to Ana, the importance of *familia* in Latino culture, matter to her:

GILLIAN: Well, I didn't particularly want to drive all the way over there, but I could see that it mattered to Ana.

THERAPIST: You could see that it was important to Ana. How did you know? Did she ask you to drive her?

GILLIAN: No, she wouldn't ask because she knows I don't like to go there. But it's what you do when you love someone. I wanted to be a loving partner for her. Her family is important to her.

The therapist would continue to reinforce the new mutuality by asking Ana what it meant to her that Gillian made this offer because she loved her and wanted to be there for her.

The therapist would also make sure to return to Ana's original story, so as not to inadvertently privilege Gillian's success at the expense of other issues important to Ana.

Couples are ready to move toward termination when they are able to recognize how they enact their developing vision of mutuality and notice when they are falling into previously taken-for-granted patterns that are counter to them. They will see their personal issues through an expanded, less blaming lens, and awareness of the social systems that impact them, which enables them to be more intentional about how they practice partnership and approach conflicts and relational repair.

MECHANISMS OF CHANGE

Third-order change is possible when couples see themselves as part of systems of systems and draw connections among society, themselves, and their relationships (McDowell et al., 2019). Socioculturally attuned practice enhances common change factors (see Chapter 13, "Common Factors in Couple Therapy," in this volume, by Davis). First, SCAFT pays close attention to extratherapeutic factors related to social location, power, and oppression. Second, therapists' critical self-awareness supports multiocular attunement to both partners and their multiple structural and identity contexts. Third, this close attunement contributes to both the therapist–client alliance and the within-system alliance. Finally, as clients become aware of dominant culture processes and constraints, it becomes possible to envision alternatives and expectancy for change.

In SERT, change is ultimately experiential; partners experience themselves, each other, and their relationships to the larger society differently. Mechanisms that lead to this change include (1) sociocultural attunement to each partner's felt identities and experience that promotes relational engagement, (2) a shift in power imbalances that supports mutual engagement in the Circle of Care, (3) experience engaging with each other from positions of mutual support, and (4) a vision of alternatives to inequitable societal power processes.

Facilitating these elements of change requires leadership by therapists who actively position their work to counter societal discourses that work against equitable relationships. SERT requires that therapists bring themselves into the social engagement system while being critically aware of societal power issues. This requires that they be humble, open to taking in the experience of others (clients), and willing and able to be transparent about their contributions to the clinical process. What will happen in any given session cannot be predetermined; however, the Circle of Care provides a clear organizing lens.

All three levels of change are involved. Third-order change in metaperspective occurs as therapy counters dominant discourses and the partners begins to see their personal issues within a larger sociocultural frame, consider alternatives to previously taken-for-granted beliefs and expectations, and engage in meaning making around relational identity and partnership. Second-order change comes about as partners enact new relationship patterns based on principles that promote mutual care. First-order change happens as new skills and practices emerge in relational context. Since the relationship is the foundation for change, change in individual symptoms is hard to sustain without also changing the power dynamic. Sometimes one individual may change through third-order/systemic awareness without corresponding partner change, which could end the relationship. Though not usual or preferred, it can be a positive outcome.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Socioculturally attuned practice is important to all clients. Dominant societal discourses have an impact on everyone. Evidence that social inequities have a substantial impact on relational well-being is considerable and long-standing. Social class, race, gender, sexual orientation, age, and abilities are linked to both physical and mental health (Centers for Disease Control and Prevention Health Disparities and Inequalities Report, 2013; McCulloch, 2001). People who face ongoing discrimination and/or less control over their lives experience more stress, which increases cortisol and other stress hormones and decreases functioning of the immune system; risk of depression and anxiety is significantly increased (Sternberg, 2001). Distressed relationships increase these risks, while mutually supportive relationships in which partners are equally able to influence each other are related to fewer depressive symptoms and increased marital satisfaction, and well-being for both men and women (Luttrell, 2017; Steil, 1997; Sternberg, 2001). Yet though couples around the globe increasingly express egalitarian values, their behaviors often do not match their ideals (e.g., Sullivan, 2005).

Ethical and Empirical Foundation for SERT

Socioculturally attuned practice emphasizes the daily, moment-by-moment ethical nature of clinical decision making. Regardless of the clinical model to which SCAFT is applied, therapists consider the impact of their clinical decisions on equity within the relationship and in the larger society. Without taking sociocultural power implications into account, clinical interventions are likely to perpetuate the status quo. Relationship experts tend to uphold societal norms that place relationship responsibility on women (Loscocco & Walzer, 2012). For example, in their study of couple therapy sessions across multiple models, ChenFeng and Galick (2015) found that therapists regularly reinforced male privilege, expected women to accommodate, and protected men from shame.

To understand how societal power processes organize mixed-gender couple relationships, Knudson-Martin and Mahoney (2009) and a team of international researchers conducted over 20 qualitative studies among couples across diverse cultural contexts and life stages. Only those who described intentional practices to counter societal gender scripts were able to achieve the shared communication virtually all said they wanted (Jonathan & Knudson-Martin, 2012). A similar study of same-sex couples in committed relationships—who were much more likely to describe equal relationship patterns—identified attunement to one another as foundational to partnerships based on fairness and relational goals (Jonathan, 2009). These studies served as the empirical foundation for developing SERT, with outcomes evaluated by the degree to which partners are able to engage mutually in the Circle of Care as they address other issues or crises (Knudson-Martin & Huenergardt, 2010).

SERT Process Research

Action researchers first studied their own practice to distinguish a set of clinical competencies that promote mutuality and transform power imbalances (Knudson-Martin, Huenergardt, et al., 2015; Knudson-Martin, Wells, & Samman, 2015). Ongoing SERT process research continues to detail key factors. A task analysis with couples addressing infidelity found that successful demonstrations of mutuality followed attention to larger societal contexts and therapist leadership that introduced alternatives to gender stereotypes (Williams et al., 2013). Study of mixed-gender couples with relationally disengaged men found it important to validate men's relational intent, accompanied by immediately highlighting the impact of men's behavior on their partners (Samman & Knudson-Martin, 2015).

Other studies explored how to apply SERT across varying treatment contexts. ChenFeng, Kim, Knudson-Martin, and Wu (2016) detailed nuances of practicing SERT with Asian American couples, attending to socioemotional cultural themes of intangible loss, quiet fortitude/not burdening others, and duty to family that complexify each aspect of the Circle of Care. Esmiol Wilson (2015) studied intersections of gendered power and relational spirituality and found that relational patterns with the Divine tend to mirror relationship patterns and are relevant to each SERT competency. A study of the clinical processes involved in working with couples coping with chronic liver disease and caregiving found barriers to mutuality created by autonomy discourse, illness-related power, and gendered power (D'Arrigo-Patrick, Samman, & Knudson-Martin, 2020).

Longitudinal study of SERT with mixed-gender adult survivor couples expanded understanding of how to work with gendered power as it intersects with trauma (Wells et al., 2017). Men with abuse histories demonstrated "disentitled power" in which they felt powerless and worthless but enacted male discourses that privileged autonomy and a focus on their own needs. A more recent study (Knudson-Martin, Kim, Gibbs, & Harmon, 2021) has detailed the importance of therapists' persistence in using sociocultural attunement to vulnerability and recognizing the varying ways vulnerability may be expressed while intervening to transform power and promote mutuality. While there have been no clinical trials quantitatively assessing the efficacy or effectiveness of this approach, the findings of these process studies provide support and guidelines for applying the approach widely across nuanced sociocultural contexts.

CASE ILLUSTRATION

The example below illustrates how a therapist used socioculturally attuned practice to contextually conceptualize infidelity and help the couple move toward third-order change and mutual engagement in the Circle of Care.

Couple Background and Presenting Problem

Curtis (age 46) and Alina (age 37), a monogamous, mixed-gender couple, have been together for 3 years and married for 2 of those years. They have a 10-month-old son named Max. Curtis is a cisgender male, able-bodied, middle-income, U.S.-born, White American. Alina is a cisgender female, able-bodied, middle-income, White immigrant from Ukraine. She has lived in the United States for 7 years and initially came on a work visa for a job in the hospitality industry. They met as coworkers while working for a major resort and casino in Las Vegas, Nevada, and currently reside in a small town in South Florida. Curtis and Alina sought couple therapy to work on issues of distrust and betrayal after Curtis learned that Alina had engaged in a year-long affair with a former coworker that ended 4 months ago.

Curtis reported that he has been having obsessive thoughts about the affair and vacillates between feelings of shock and anger. Alina blamed herself for their relationship issues and has been struggling with appetite and sleep. After ruling out risk factors such as potential intimate partner violence, self-harm, and substance use, the therapist asked about the couple's hopes for therapy. Curtis reported uncertainty about continuing in the marriage but worried about the consequences of divorce, explaining that he grew up without his father and thus could not imagine splitting custody of their son. Alina quietly nodded her head in agreement with Curtis's statement that their top priority is to be there for their son and ensure an intact family unit and stable home environment for him.

Assessing Flow of Power and Mutuality

Alina sat tensely with a stoic look on her face until the therapist asked how Curtis learned about the affair, and how this knowledge was impacting the couple's current relationship. She explained that Curtis had learned about the affair through an old e-mail he found in her account, but that she had been planning to break the news 4 months earlier when she ended the affair. She berated herself for not having done so sooner. She owned that the affair had been "all her fault," took full responsibility for the pain she had caused, and stated that she was willing to do anything to repair the relationship. Curtis said Alina's explanation was inadequate and did not make sense to him, and he questioned her ability to be fully honest. As the therapist tracked this initial description of the couple's issues, she observed an inequitable flow of power and limited mutuality and sought to expand the contextual lens.

Using Sociocultural Attunement to Interrupt Flow of Power

The therapist noticed the one-down position in which both partners put Alina and saw the full responsibility she was taking for the relationship issues. She noted that they both held strongly to the idea of affairs as "bad" and saw cheating as an individual issue. She recognized taken-for-granted societal assumptions in this expectation that Alina should take relational responsibility to fix things. She conceptualized how this pattern might relate to larger societal assumptions about infidelity in monogamous, cisgender, mixed-gender relationships and prescriptions around what it means for the offending partner to take accountability. She also saw the influence of misogynous beliefs that tend to legitimize this behavior from men but pathologize women for it.

Seeing Partners through Their Respective Sociocultural Contexts

As the therapist curiously explored the couple's relationship history, she paid close attention to Alina's migration story and the circumstances that surrounded their decision to leave their jobs in Las Vegas and relocate across the country. This provided important context to their invisible power dynamics. Alina recounted the significance of her job in Las Vegas to her identity, her responsibility to financially support her parents in Ukraine, and the economic mobility her job had provided. She reported that within 3 years of arriving in the United States, she had worked her way into the role of associate operations manager. She referred to those years as "the best of her life." As someone who had long struggled with depression and anxiety, she noted that during her time in Las Vegas, she felt confident, capable, and optimistic.

When the Alina and Curtis decided to have a child, being near family was a priority. The therapist asked how they made this decision. Curtis stated that when considering a move to either Ukraine to be by Alina's parents or Florida to be by Curtis's mother, Florida was the logical choice because the United States offered more work opportunities. Alina looked sullen as she nodded her head in agreement. Although the decision to stay in the United States was supposedly mutual, the therapist noted that due to the global economic disparities surrounding their options, Ukraine had never been a legitimate choice. However, due to the illusion of a shared decision, neither partner had acknowledged the significance of Alina's accommodation, that she and her family had to give up hope for her return.

The therapist asked Curtis what he thought the transition to Florida had been like for Alina. He recalled that it had been difficult. In leaving the resort, Alina lost her work visa and needed a spousal visa to find new work and fully function in all other aspects of her life. Because there was a backlog with U.S. Immigration around processing spousal visas, the wait was longer than anticipated. The therapist attuned to Alina's socioemotional experience of the delay. Alina reported growing increasingly anxious as time stretched on and on. She worried she might not ever receive her visa. The reality that she had sacrificed her financial stability and future by leaving her job in Las Vegas started to weigh in. She described that period as a bleak one in which she felt mounting pressure, knowing her parents in Ukraine were counting on her, but completely powerless. When the therapist probed about feeling powerless, Alina explained that without legal status, she felt as though she did not exist. Furthermore, although she looked like a White American, her heavy Eastern European accent identified her as a cultural outsider in the community. The therapist began to apprehend Alina's felt sociocultural experience and the multiple societal discourses regarding work, family, and gender that nuanced the power imbalance and its relational consequences.

Exploring How Sociocultural Influences Shaped Assumptions about the Affair

The therapist wondered how dominant cultural assumptions about affairs might compound the power imbalance, so she asked the partners how they made sense of it. Alina insisted that she must either be a "bad" person or "crazy" in some way to have an affair when she had such an "ideal" partner. She could not understand why she had done this. She described Curtis as a man who was going above and beyond to make her happy—planning surprises, showering her with gifts, providing material comforts, and connecting her with his social support network in Florida. She described Curtis as kind and gentle, unlike "most men." Curtis silently agreed with Alina's description of both of them and stated that he thought she had been "happy."

The therapist noted that the couple held unexplored gender stereotypes that supported male dominance. They idealized Curtis's countercultural demonstrations of masculinity without awareness that this inadvertently reified his position and positive self-image, while invalidating Alina's societally expected gender role of the appreciative and affirming partner. They also missed that Curtis's insistence of "doing" for Alina and needing her to be "happy" had been unwittingly paternalistic. It also overlooked the feelings of fear, desperation, and regret that Alina had silently endured, and the cultural expectation that she shield Curtis and his mother from feeling her burden.

In order to promote a shift in this power imbalance, the therapist attuned to Curtis's sociocultural emotion and moved toward his vulnerability.

THERAPIST: Curtis, I can see that this affair has left you shocked and hurt, and part of this is because you hear Alina say that you were the ideal husband. I can understand how that is confusing to hear. Can you talk about the kind of partner you tried to be?

CURTIS: That's one of the things that makes this hardest for me to understand—that I made her happy, yet she still decided to cheat. It would help if I thought I had been a "bad" husband, but I wasn't!

THERAPIST: So, you could make sense of the cheating if you had been a different kind of man. How do you mean?

CURTIS: Well, you know, if I was a jerk or something and abusive or totally insensitive. I could probably see cheating happening then.

THERAPIST: But you weren't that way. In fact, you intentionally tried to be a "good" husband. Is that right? Where did you learn what it means to be a "good" husband?

CURTIS: I don't know. I didn't want her to regret leaving her job in Las Vegas and resent me—I needed to make this work for her. I was worried for her and unable to fix her situation. I also couldn't stand to see her unhappy!

THERAPIST: (*softly*) So it was your job to make her happy. What would it say about you if your wife was unhappy?

CURTIS: I'm not a good man. I'm not good enough. She'll want someone else.

This conversation continued to explore Curtis's sense of vulnerability and ideas about masculinity, relationships, and his responsibility. It began to expose the couple's second-order change ideas that did not shift the power system embedded in constructions of gender, and it highlighted and expanded on Curtis's relational values.

Develop a Contextual, Relational Understanding to the Issue

To name the relational consequences of the power imbalance, the therapist acknowledged the relational work Alina had been doing to act as though she was okay when she was not. She highlighted Alina's sacrifices for the relationship, punctuated the resulting losses she disproportionately incurred from the couple's decisions, and named the powerlessness she experienced related to not having legal status in the United States. The therapist "got" that because Alina had willingly agreed to leave Las Vegas, and because Curtis was so focused on making sure she was okay, the only option she had as a "good partner" was to appear grateful and hide her stress. She contextualized the affair as a mechanism that enabled her to maintain her facade of contentment, while accessing a source of support that provided opportunity to express her silent distress.

Alina connected to part of this attuned conceptualization. Yet she adamantly rejected permission to take in this validation, claiming that regardless of her experience, it did not excuse what she had done. The only way Alina could imagine the relationship continuing was if she lived with guilt hanging over her and continually proved her remorse, so Curtis could potentially trust her again. She asked the therapist to outline steps for her to accomplish this, while Curtis stated doubts that she could ever earn back his trust.

The therapist saw that the couple needed help envisioning possibilities for healing the relationship beyond Alina carrying sole blame. She deconstructed their unexamined assumptions about individualism and competition, which meant only one partner's pain could be honored, and Alina perceived attunement to her experience a negation of her betrayal. The therapist recognized that part of what constrained the couple's vision of therapeutic change was their assumption that the affair was simply a reflection of Alina's issues, without awareness of how it functioned relative to the inherent contextual imbalances in the relationship. Through the lens of her migrant status, her life with Curtis in the United States was seen as "prized." The couple needed to understand the affair through this third-order lens, so that they could shift from individualistic narratives of affairs as actions by "bad" people toward a relationally transformative understanding.

Promoting Mutuality and Developing a Shared Vision of Relational Healing

The therapist demonstrated responsive persistence (Sutherland et al., 2013) toward promoting mutuality and shifting from individual to shared relational responsibility by highlighting the unintended but very inherent and real imbalances between what each partner had to do to maintain the relationship beyond Las Vegas. She validated the couple's relational intents and helped them share responsibility for consequences of their current power imbalance. She suggested that relational repair would require connecting to Alina's contextual experience, affirming its importance, and inviting it to coexist with Curtis's pain. She acknowledged that this would be a difficult but critical part of the healing process. She facilitated Curtis's attunement to Alina's visible distress in session, while staying connected to his own emotional experience. She facilitated enactments of shared vulnerability by helping Alina accept Curtis's emotional care and allowing him to witness and connect with her.

Increasing mutual engagement in the Circle of Care was challenging because of deeply internalized societal discourses about infidelity and gender that maintained the couple's contextual power imbalance. While making progress toward a more mutually supportive relationship, it was easy to revert to individualistic notions of accountability. When Curtis would emote pain, Alina would self-flagellate and cut off from her own experience. When Alina opened up about her feelings of powerlessness, Curtis's feelings of impotence as a man to "fix" her situation were triggered. These moments of heightened emotional reactivity required the therapist to maintain a deliberately slow, socioculturally attuned pace in session, so she could stay open to the clients' felt experience, increase awareness about unhelpful patterns, help them work through resistance, and engage the partners in the social engagement system (Porges, 2009).

Over weeks of facilitated practice, the therapeutic shifts toward shared vulnerability and attunement started to present an alternative vision of partnership. The therapist helped the couple envision and detail a new model that expanded their gender socialization. Curtis learned to soothe his anxiety around witnessing Alina's vulnerable emotions and invite her to express them. Alina learned to validate her emotions and value the connection it brought through sharing them. They learned to share responsibility for broaching difficult conversations and resist old tendencies to avoid uncomfortable emotions.

As Curtis and Alina became more aware of the impact of structural inequities related to larger economic systems, nation of origin and legal status, and patriarchy on their relationship, they were able to respond to them more intentionally. The therapist and couple discussed that maintaining an equitable relationship based on mutual influence and shared relational responsibility would not be easy, that these societal disparities would continue to be present and might periodically invite unhelpful emotional reactions. However, when they recognized the contextual nature of their struggles, instead of fixing and protecting each other, they could work together toward their relational goals, with the Circle of Care principles as a guide.

CONCLUDING COMMENTS

Socioculturally attuned practice applies to all clients, not just those who experience "marginalization." People across many cultural contexts regularly internalize assumptions privileged by dominant, White, Western cultures without realizing that they are doing so. These assumptions also permeate what most clinicians are taught. SCAFT principles may be applied with any clinical model to connect intimate relational processes with larger societal contexts and orient therapy toward equity and justice. The SERT model provides clear guidance for how to do this work. Four practices are especially important. First, expand the lens to attune to each partner's unique felt sociocultural experience, especially as vulnerability and societal power processes intersect. Second, assess the flow of power between partners and direct interventions to interrupt power imbalances, which usually means that each partner is not asked to do the same thing. Third, pay attention to the values represented in the clinical encounter. Whose interests are promoted? How are relational values minimized or centered? Finally, view professional ethics through a socially responsible lens that is accountable for the consequences of clinical choices and facilitates third-order change.

SUGGESTIONS FOR FURTHER STUDY

ChenFeng, J., Kim, L., Knudson-Martin, C., & Wu, Y. (2016). Application of socio-emotional relationship therapy with couples of Asian heritage: Addressing issues of culture, gender, and power. *Family Process, 56,* 558–573.

Knudson-Martin, C., & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking social context and couple interaction. *Family Process, 49,* 369–386.

Knudson-Martin, C., Kim, L., Gibbs, E., & Harmon, R. (2021). Sociocultural attunement to vulnerability in couple therapy: Fulcrum for changing power processes. *Family Process, 60,* 1152–1169.

Knudson-Martin, C., Samman, M. A., & Wells, M. A. (Eds.). (2015). *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction*. Cham, Switzerland: Springer.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2018). *Socioculturally attuned family therapy: Guidelines for equitable practice*. New York: Routledge.

REFERENCES

Almeida, R., V., & Tubbs, C. Y. (2020). Intersectionality: A liberation-based healing perspective. In K. Wampler, R. B. Miller, & R. B. Seedahl (Eds.) *The handbook of systemic family therapy* (Vol. 1, pp. 227–249). Hoboken, NJ: Wiley.

Anderson, S., & Johnson, L. (2010). A dyadic analysis of the between and within-system alliances on distress. *Family Process, 49,* 229–235.

Auerswald, E. H. (1971). Families, change, and the ecological perspective. *Family Process, 10,* 263–280.

Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. Northvale, NJ: Aronson.

Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: Guilford Press.

Centers for Disease Control and Prevention. (2013).

Health Disparities and Inequalities Report. www.cdc.gov/mmwr/pdf/other/su6203.pdf.

ChenFeng, J., & Galick, A. (2015). How gender discourses hijack couple therapy—and how to avoid it. In C. Knudson-Martin, M. A. Wells, & S. K. Samman (Eds.), *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction* (pp. 41–52). Cham, Switzerland: Springer.

ChenFeng, J., Kim, L., Knudson-Martin, C., & Wu, Y. (2016). Application of socio-emotional relationship therapy with couples of Asian heritage: Addressing issues of culture, gender, and power. *Family Process, 56,* 558–573.

D'Arrigo-Patrick, E., Samman, S. K., & Knudson-Martin, C. (2020). Moving from "I" to "we": A grounded theory analysis of couple therapy with liver patients and their partners. *Family Process, 59,* 1517–1529.

D'Arrigo-Patrick, J., Hoff, C., Knudson-Martin, C., & Tuttle, A. R. (2017). Navigating critical theory and postmodernism: Social justice and therapist power in family therapy. *Family Process, 56,* 574–588.

Emiol Wilson, E. (2015). Relational spirituality, gender, and power: Applications to couple therapy. In C. Knudson-Martin, M. A. Wells, & S. K. Samman (Eds.), *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction* (pp. 121–132). Cham, Switzerland: Springer

Falicov, C. J. (2014). Psychotherapy and supervision as cultural encounters: The multidimensional ecological comparative approach framework. In C. A. Falender, E. P. Shafranske, & C. J. Falicov (Eds.), *Multiculturalism and diversity in clinical supervision* (pp. 29–58). Washington, DC: American Psychological Association.

Fosha, D. (2009). Emotion and recognition at work: Energy, vitality, pleasure, truth, desire, and the emergent phenomenology of transformational experience. In D. Fosha, D. J. Siegel, & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development and clinical practice* (pp. 172–203). New York: Norton.

Gergen, K. J. (1997). *Realities and relationships: Soundings in social construction.* Cambridge, MA: Harvard University Press.

Goldner, V. (1985). Feminism and family therapy. *Family Process, 24,* 31–47.

Hare-Mustin, R. (1978). A feminist approach to family therapy. *Family Process, 17,* 181–194.

Hofstede, G. (2001). *Culture's consequences.* Thousand Oaks, CA: SAGE.

Jonathan, N. (2009). Carrying equal weight: Relational responsibility and attunement among same-sex couples. In C. Knudson-Martin & A. R. Mahoney (Eds.), *Couples, gender and power: Creating change in intimate relationships* (pp. 79–103). New York: Springer.

Jonathan, N., & Knudson-Martin, C. (2012). Building connection: Attunement and gender equality in heterosexual relationships. *Journal of Couple and Relationship Therapy, 11,* 95–111.

Knudson-Martin, C. (2013). Why power matters: Creating a foundation of mutual support in couple relationships. *Family Process, 52,* 5–18.

Knudson-Martin, C. (2016). Gender in couple and family life: Toward inclusiveness and equality. In S. Kelly (Ed.), *Issues in couple and family therapy: Across socioeconomics, ethnicities, and sexualities* (pp. 153–180). New York: Praeger.

Knudson-Martin, C., & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking social context and couple interaction. *Family Process, 49,* 369–386.

Knudson-Martin, C., & Huenergardt, D. (2015). Bridging emotion, societal discourse, and couple interaction in clinical practice. In C. Knudson-Martin, M. Wells, & S. Samman (Eds.), *Socio-emotional relationship therapy.* Cham, Switzerland: Springer.

Knudson-Martin, C., Huenergardt, D., Lafontant, K., Bishop, L., Schaepper, J., & Wells, M. (2015). Competencies for addressing gender and power in couple therapy: A socio-emotional approach. *Journal of Marital and Family Therapy, 41,* 205–220.

Knudson-Martin, C., Kim, L., Gibbs, E., & Harmon, R. (2021). Sociocultural attunement to vulnerability in couple therapy: Fulcrum for changing power processes. *Family Process, 60,* 1152–1169.

Knudson-Martin, C., & Mahoney, A. (Eds.). (2009). *Couples, gender, and power: Creating change in intimate relationships.* New York: Springer.

Knudson-Martin, C., McDowell, T., & Bermudez, J. M. (2020). Sociocultural attunement in systemic family therapy. In K. S. Wampler, R. B. Miller, & R. B. Seedall (Eds.), *The handbook of systemic family therapy* (Vol. 1, pp. 619–637). Hoboken, NJ: Wiley.

Knudson-Martin, C., Samman, M. A., & Wells, M. A. (Eds.). (2015). *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction.* Cham, Switzerland: Springer.

Loscocco, K., & Walzer, S. (2013). Gender and the culture of heterosexual marriage in the United States. *Journal of Family Theory and Review, 5,* 1–14.

Luttrell, T. (2016). *Exploring factors in the relationship balance assessment* (Doctoral dissertation). https://scholarsrepository.llu.edu/cgi/viewcontent.cgi?article=1389&context=etd.

Mahoney, A., R., & Knudson-Martin, C. (2009). The social context of gendered power. In C. Knudson-Martin & A. Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 17–29). New York: Springer.

McCulloch, A. (2001). Social environments and health: Cross sectional national survey. *British Medical Journal, 323,* 208–209.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2018). *Socioculturally attuned family therapy: Guidelines for equitable practice*. New York: Routledge.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2019). Third-order thinking in family therapy: Addressing social justice across family therapy practice. *Family Process, 58,* 9–22.

McGoldrick, M., Anderson, C. M., & Walsh, F. (1989). *Women in families: A framework for family therapy.* New York: Guilford Press.

Minuchin, S., Montalvo, B., Guerney, B., Rosman, B., & Shumer, F. (1967). *Families of the slums: An exploration of their structure and treatment.* New York: Basic Books.

Nicholeau, A., Choau, S. T., Kang, Y. J., & Knudson-Martin, C. (2016). Doing what it takes to make it work: Flexibility, relational focus, and stability among long-term couples with children. *Journal of Family Issues, 37,* 1639–1657.

Oswald, R. F., Kuvalanka, K. A., Blume, L. B., & Berkowitz, D. (2009). Queering "the family." In S. A. Lloyd, A. L. Few, & K. R. Allen (Eds.), *Handbook of feminist family studies* (pp. 43–55). Thousand Oaks, CA: SAGE.

Pandit, M., Kang, Y. J., Chen, J. Knudson-Martin, C., & Huenergardt, D. (2014). Practicing sociocultural attunement: A study of couple therapists. *Journal of Contemporary Family Therapy, 36,* 518–528.

Porges, S. W. (2009). Reciprocal influences between body and brain in the perception and expression of affect. In D. Fosha, D. J. Siegel, & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development and clinical practice* (pp. 27–54). New York: Norton.

Richards, J. C., Jonathan, N., & Kim, L. (2015). Building a circle of care in same-sex couple relationships: A socio-emotional relational approach. In C. Knudson-Martin, M. A. Wells, & S. K. Samman (Eds.), *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction* (pp. 93–106). Cham, Switzerland: Springer.

Samman, S. K., & Knudson-Martin, C. (2015). Relational engagement in heterosexual couple therapy: Helping men move from "I" to "we." In C. Knudson-Martin, M. A. Wells, & S. K. Samman (Eds.), *Socio-emotional relationship therapy: Bridging emotion, societal context, and couple interaction* (pp. 79–92). Cham, Switzerland: Springer.

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford Press.

Silverstein, R., Bass, Linda B., Tuttle, A., Knudson-Martin, C., & Huenergardt, D. (2006). What does it mean to be relational?: A framework for assessment and practice. *Family Process, 45,* 391–405.

Steil, J. (1997). *Marital equality: Its relationship to the well-being of husbands and wives.* Thousand Oaks, CA: SAGE.

Sternberg, E. (2001). *The balance within: The science connecting health and emotions.* New York: Freeman.

Sullivan, O. (2005). *Changing gender relations, changing families; Tracing the pace of change over time.* Lanham, MD: Rowman & Littlefield.

Sutherland, O., Turner, J., & Dienhart, A. (2013). Responsive persistence: Part I. Therapist influence in postmodern practice. *Journal of Marital and Family Therapy, 39,* 470–487.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). *The invisible web: Gender patterns in family relationships.* New York: Guilford Press.

Wells, M. A., Lobo, E., Galick, A., Knudson-Martin, C., Huenergardt, D., & Schaepper, J. (2017). Fostering trust through relational safety: Applying SERT's focus on gender and power with adult-survivor couples. *Journal of Couple and Relationship Therapy, 16,* 122–145.

Wetherell, M. (2012). *Affect and emotion: A new social science understanding.* Thousand Oaks, CA: SAGE.

Williams, K., Galick, A., Knudson-Martin, C., & Huenergardt, D. (2013). Toward mutual support: A task analysis of the relational justice approach to infidelity. *Journal of Marital and Family Therapy, 39,* 285–298.

INTEGRATIVE APPROACHES

CHAPTER 13

Common Factors in Couple Therapy

Sean Davis

BACKGROUND

Psychotherapy works and works well, though outcomes have not improved much over the last several decades despite the development of new approaches, and we know relatively little about what makes therapy effective and why (Wampold & Imel, 2015). These findings from the psychotherapy literature are largely mirrored in the couple therapy literature (Shadish & Baldwin, 2003). Despite this, the field largely continues with business as usual in research and training. A critical look at the assumptions underlying psychotherapy, and a consideration of all variables that make therapy work and how, is at the heart of the common factors movement.

From the origins of psychotherapy at the beginning of the 19th century, key figures such as Freud, Jung, and Adler debated the best form of analysis, emphasizing their respective theories and associated methods. Little emphasis was placed on other, potentially curative elements of therapy they all had in common, such as the therapeutic alliance. After World War II, the number and type of therapies increased exponentially, each emphasizing the importance of different aspects of the human experience, from behaviors, cognitions, and emotional expressiveness to family dynamics. Proponents of each theory vied for legitimacy by emphasizing their seemingly unique contributions and downplaying others' importance. This was especially true in family therapy, as some strategic theorists (Watzlawick, Weakland, & Fisch, 1974) went so far as to purposefully downplay elements of therapy, such as therapeutic alliance, that were later shown to be core common factors of successful family therapy. The assumption underlying this climate was that the effectiveness of therapy was due to the unique contributions of a particular theory. Little, if any, attention was paid to aspects of therapy that were shared across theories. There were, however, a few exceptions to this trend.

The History of Common Factors in Psychotherapy

British psychologist Hans Eysenck criticized the mental health disciplines throughout the 1950s and 1960s for their ineffectiveness (Bergin & Lambert, 1978). He noted that about two-thirds of patients diagnosed as neurotic improved after 2 years of treatment. That seems admirable, except Eysenck noted that two-thirds of patients improved in the same amount of time without treatment. This claim triggered several debates and led to a crisis of confidence for many clinicians.

Eysenck's claims were a likely catalyst for the rise in comparative efficacy trials that followed as proponents of various models sought to establish the credibility of their approach (Bergin & Lambert, 1978). Psychotherapy has always been characterized by practitioner loyalty to different theoretical camps; now the race was on to gather empirical data to demonstrate which was the best. This trend reached a peak in 1993 when, at the request of a leading cognitive-behavioral psychologist, the Division of Clinical Psychology of the American Psychological Association formed a task force to essentially summarize all of the comparative efficacy results to date and announced a winner (*Task Force Report on Promotion and Dissemination of Psychological Procedures*, 1993). This move further divided an already fractured field. As practitioners validated by the Division's findings celebrated, others noted that "however well intended these efforts may be, they scream of scientific or theoretical arrogance" (Asay & Lambert, 1999).

The surge in comparative efficacy trials led to an unanticipated result, as researchers began to conduct meta-analyses of these studies. A meta-analysis, or an analysis of analyses, allows researchers to compile the results of multiple studies and obtain an "effect size," which is a standardized statistic that shows how far away the mean of the test group (e.g., people receiving treatment) is from the mean of the control group (e.g., people receiving no treatment, or treatment as usual). The largest meta-analysis at the time (Smith, Glass, & Miller, 1980) found results that have been replicated many times since and form the main empirical basis for the common factors movement: Most tested models work well, but no one model works significantly better than another (Sprenkle & Blow, 2004). As the number of meta-analyses grew, this finding eventually became one of the most robust in the individual psychotherapy and couple therapy literature (Wampold & Imel, 2015). These findings understandably added to the tension of the time, as they implied that the "empirically validated" title should be shared beyond those groups that felt they had earned it.

These meta-analytic findings left the field with more questions than answers. If all tested models work but work equally well, what makes therapy effective? Do models even matter? If so, what effective ingredients do they share in common, since it is not their often-touted unique contributions? If not, what *does* matter, and are those things unique to therapy or shared with other healing disciplines? Or do differences exist, but meta-analysis is too blunt of an instrument to detect these differences? These questions left an already disrupted field searching for answers, which many found in a few prescient voices decades earlier.

Do All Deserve a Prize?

Saul Rosenzweig (1936), in the first paper on common factors, emphasized the importance of the therapeutic alliance and of having a coherent approach to making sense of a client's problems. He also coined the term "the dodo bird verdict"—borrowed from *Alice in Wonderland* (when the dodo bird reports a run around a lake in which "everyone has won and must have prizes")—to illustrate his claim that "besides the intentionally utilized methods and their consciously held theoretical foundations there are inevitably certain unrecognized factors in any therapeutic situation—factors that may be even more important than those being purposefully employed" (p. 412). The dodo bird verdict was later popularized by Luborsky, Singer, and Luborsky (1975).

Jerome Frank (1961) published his influential book, *Persuasion and Healing*, in which he made a case for golden threads running through all healing efforts, not just psychotherapy. He (and later with his daughter; Frank & Frank, 1991) made the claim that therapy in all its various forms should be thought of as a single entity. They suggested that therapy, as well as all healing environments, include the following four elements: (1) an emotionally charged confiding relationship with a helper; (2) a healing context; (3) a rationale that provides a believable explanation of the person's problem and how to resolve it; and (4) a procedure or set of rituals that involves active participation, and that everyone involved views as a credible means of restoring health.

Michael Lambert

In 1992, Michael Lambert published a highly influential article in which he concluded that the following four variables accounted for all of the change in psychotherapy: (1) client variables and other extratherapeutic factors, responsible for 40% of the variance in outcomes (i.e., client attributes such as internal locus of control; and things outside the control of therapy, such as changing jobs or recovering from a health condition); (2) the therapeutic alliance, responsible for 30% of the variance; (3) hope and placebo factors, responsible for 15% (i.e., both the therapist and client believing therapy will help); and (4) model-specific techniques, responsible for the remaining 15%. To date, Frank and Frank (1991) as well as Lambert's designations remain the most popular categorizations of common factors.

Bruce Wampold

Bruce Wampold (2001) used the four variables of Frank and Frank (1991) to guide the research detailed in his book, *The Great Psychotherapy*

Debate. Wampold's meta-analysis is particularly convincing, as he only used studies that compared two bona-fide treatments to each other rather than studies that compared a bona-fide treatment to placebo or treatment as usual conditions. Wampold also rigorously controlled for confounding variables (e.g., researcher allegiance), and included a review of "component analysis studies"—studies that measure differences in outcome based on adding or subtracting key elements of a model.

Wampold's analysis (2001; Wampold & Imel, 2015) confirmed that the Frank and Frank (1991) categorization accounted for about 70% of the outcome variance in therapy. Furthermore, he suggested that, at the most, 8% of the outcome variance is accounted for by the unique contributions of a given model—a percentage much smaller than Lambert's (1992) proposed 15%.

American Psychological Association Division of Psychotherapy Report

Even though common factors remained a minority viewpoint, momentum continued to build with the publication of the American Psychological Association Division of Psychotherapy Report (Norcross, 2002). This represented the first time a major mental health organization devoted resources to the study of common factors. The group was tasked with examining which common factors had sufficient empirical basis to earn the designation of "established." They found overwhelming support for the therapeutic alliance being related to outcome. More specifically, they found that high levels of therapist empathy, goal consensus between the therapist and client, and collaboration were elements of the therapeutic alliance associated with positive outcomes. Similarly, they found that therapists enjoyed better outcomes if they adapted their treatment to maintain the therapeutic alliance and to match the level of functional impairment and coping style of the client.

Subsequent efforts by the task force refined the list of relationship factors that are considered "demonstrably effective" and "probably effective" (Norcross & Lambert, 2018). Relationship factors that are demonstrably effective enjoy strong empirical support. Specifically, they found the therapeutic alliance to be demonstrably effective in individual, couple, child, and adolescent therapy. In group therapy, "group cohesion"—group members feeling connected to each other—played a similar role as the therapeutic alliance in individual therapy. Maintaining an atmosphere of collaboration and obtaining a consensus on the goals of therapy were demonstrably effective, as were the concepts of empathy, positive regard, and affirmation. Last, collecting and delivering client feedback was also deemed demonstrably effective.

The task force found several relationship factors that were deemed probably effective, which means they enjoyed some empirical support, but not as much as those variables deemed demonstrably effective. Probably effective relationship aspects of the alliance include congruence/genuineness, emotional expression, cultivating positive expectations, promoting treatment credibility, managing countertransference, and repairing alliance ruptures. In a volume following up the most recent report, Norcross, Lambert, and Wampold (2019) also highlight the transcendent importance of cultural adaptation, stage of change, therapist self-disclosure, immediacy, and sensitivity to a client's gender identity and sexual orientation.

Today, the legitimacy of common factors is no longer debated as fervently as it once was in the individual psychotherapy field. The divisive tone of early common factors proponents has calmed down, and model developers routinely acknowledge that much of what makes their approach effective is inherent in the process of therapy itself (Benson, McGinn, & Christensen, 2012). Many from both camps have found unity in the search for *principles of change,* or the discovery of concise statements of principles that explain effective treatment (Snyder, 1999).

The History of Common Factors in Couple and Family Therapy

Couple and family therapy (CFT) has been slow to adopt a common-factors framework, as it was over half a century after the field's founding before the first mention of common factors was found in the literature.

Sprenkle and Blow's Moderate Common-Factors Approach

Couple therapists Douglas Sprenkle and Adrian Blow (2004) proposed a moderate common-factors approach, which they contrasted with what they viewed as the more extreme approaches of Wampold (2001) and Hubble, Duncan, and Miller (1999). According to Sprenkle and Blow (2004), previous common-factors scholars had gone too far by implying that since all models worked equally well, models didn't matter. They took issue with the more extreme notion that whether a therapist was using tarot cards or a bona-fide couple therapy model was of no consequence, as long as the therapeutic alliance was strong and everyone involved believed it would help. Sprenkle and Blow proposed that models are important, since they are one of the vehicles through which common factors operate. Having a model not only conveys useful information but it also allows a therapist to have confidence in their approach, which in turn allows a client to have confidence in the therapist.

Sprenkle and Blow (2004) also argued that while the therapeutic alliance was a necessary part of treatment, it was not sufficient; other aspects of treatment needed to be present as well, such as a client's hard work, favorable external life circumstances, and so forth. In their view, other common-factors scholars went too far in claiming that since the therapeutic alliance had the strongest empirical base, it was the only part of therapy that mattered.

Additionally, Sprenkle and Blow (2004) thought most common-factors scholars' view of clinical trials research was too dim. Many of these scholars argued that since clinical trials had failed to show meaningful differences, they should be abandoned. Sprenkle and Blow instead claimed that just because no meaningful differences between treatments had been found to date did not mean they would not in the future as methods became more refined. Some treatments might be shown to be more effective for certain problems than others (e.g., some findings suggest that exposure-based approaches produce better results for phobias than other approaches; Asay & Lambert, 1999). Furthermore, process research could be woven into clinical trials to better understand why an approach worked. Overall, Sprenkle and Blow took a "both–and" stance in the debate over common versus specific factors, rather than "either–or" stance. Sprenkle and Blow's contributions to common factors unique to couple therapy are reviewed later in the chapter.

Davis and Piercy's Common-Factors Metamodel

As with individual psychotherapy, the beginning of the common-factors movement in CFT was largely theoretical. Sean Davis and Fred Piercy added the first empirical study to the CFT common-factors literature with a qualitative grounded theory study in which they interviewed prominent CFT model developers, their clients, and former students of the model developers and their clients. The assumption was that any themes existing across all of the practices might illuminate common factors for later quantitative testing. Themes were found across all of the interviews and combined to form a metatheory of change (Davis & Piercy, 2007a, 2007b). The Davis and Piercy metamodel was unique in that it outlined how different common factors might interact to produce change at different stages of therapy rather than simply listing different common factors. For example, in the early stages of couple therapy, "hope" was found to be an interaction between positive expectations created by the referral source, the therapist's reassuring, nonanxious presence, and the therapist offering interventions that made conceptual sense to the client and were delivered in a way that was easy to hear. Similar findings were outlined for each stage of the couple therapy process.

Sprenkle, Davis, and Lebow

Sprenkle and Blow's moderate common factors approach and Davis and Piercy's meta-model formed much of the foundation for the first book on common factors in CFT, *Common Factors in Couple and Family Therapy: The Overlooked Foundation for Effective Practice* by Douglas Sprenkle, Sean Davis, and Jay Lebow (2009). This book summarized what was known about common factors in CFT at the time and expanded on the ideas articulated in the authors' prior work. It remains the only book devoted entirely to common factors in CFT.

The Current State of CFT Common-Factors Literature

As of 2020, two decades of common-factors literature have yielded just under 40 scholarly publications on this topic (D'Aniello & Fife, 2020). Most of the literature is theoretical, though many meta-analytic and process research studies provide indirect empirical support for common-factors hypotheses (Sprenkle et al., 2009). The number of common-factors publications has increased significantly in recent years, indicating a greater interest in the ideas in CFT.

What Are the Common Factors?: Model-Independent and Model-Dependent Categorizations

I classify common factors in couple therapy as either model-independent or model-dependent. Model-independent common factors (Davis &

Piercy, 2007b) refer to general aspects of the treatment setting that exist regardless of the model being used, such as the therapeutic alliance, hope, and therapist or client variables. They are what traditionally are thought of as common factors. However, meaningful commonalities exist not only in the treatment setting itself but also in the way therapists using diverse models conceptualize and intervene. Model-dependent common factors (Davis & Piercy, 2007a) refer to the overlap found among the ways different models conceptualize problems and strategies shared when intervening with those problems (Lebow, 2014), such as changing the thinking, doing, or feeling (Sprenkle & Blow, 2004). Most of this chapter focuses on model-independent factors, but first we will turn to a brief overview of model-dependent factors.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

If no single model has been shown to be differentially effective relative to others, what is the purpose of a model? Just because models account for little of the variance in outcome does not mean that models do not matter. On the contrary, models are an indispensable (and arguably unavoidable) aspect of treatment. They are intertwined with other common factors in that they help therapists have confidence in their work, which in turns helps clients have confidence in the therapists. They also provide a direction for treatment and offer rituals to help get there, both of which are important aspects of the therapeutic alliance. Much like a constellation chart allows an astronomer to see patterns among a sea of stars, a model allows a therapist to see order amid a couple's chaos. A model allows a therapist to make sense of the myriad disparate bits of information that are presented at any given moment in a therapy session. A model tells a therapist which of those bits to pay attention to and which to let pass by, which to accentuate, which to downplay, which to try to alter, and so forth. To do this, every viable model answers three sets of questions (Johnson, 2019):

1. What is going on here? What is the focus of intervention?
2. What interventions can I use to guide the couple toward a healthier relationship?
3. What is the goal? How do I know when I can stop intervening? What does "health" look like?

At the most abstract philosophical and theoretical level, most models seem to offer widely disparate answers to these questions. Models also differ at the most concrete level of interventions; the movement around the room and physical touching of an experiential therapist looks different than the more removed questioning of a narrative therapist. These differences are compounded by the unfounded claims of superiority often made by the most ardent supporters of a particular model. But between these two levels of abstraction there is more overlap than it initially seems. Absent model-specific language, many models recommend similar processes as a target of intervention and guide couples toward a similar picture of a healthy relationship. Most differences are stylistic in terms of what their interventions look like and how they are delivered. These differences are useful, as they allow therapists to match their approach to a couples' stylistic preference, but when it comes to the target of the interventions and their intended effect, there is considerable overlap among major models of couple therapy (Davis, Lebow, & Sprenkle, 2012). These areas of overlap constitute model-dependent common factors.

For example, at the theoretical level, an intergenerational model such as Bowenian therapy (see Chapter 9, "Intergenerational Factors in Couple Therapy," in this volume, by Fishbane) and emotionally focused therapy (EFT; see Chapter 6, "Emotionally Focused Couple Therapy," also in this volume, by Johnson, Wiebe, & Allan) seem worlds apart, and proponents of each have a long history of taking jabs at each other. But take away the model-specific language and each model is targeting its interventions at similar processes and guiding couples toward similar ends, albeit with different interventions.

Generally speaking, what do EFT's insecurely attached persons look like in a relationship? Due to a history of over- or underinvolved parenting, they worry about the emotional availability and dependability of their partners, and either rush toward their partner (anxious attachment) or pull away (avoidant attachment) when the relationship feels threatened. They have difficulty regulating their emotions, and deal with perceived rejection by either becoming emotionally cut off from or obsessively preoccupied with the state of their relationship.

But how about Bowen's undifferentiated person? Being undifferentiated is an internal state learned from either over- or underinvolved parents that leads a person to form either emotionally cut off or enmeshed relationships—patterns that are exacerbated by anxiety. In other words, take away each model's idiosyncratic jargon and the internal emotional worlds and external behaviors (i.e., the target of intervention) of insecurely attached and undifferentiated persons are similar, if not identical.

The same could be said for each model's definition of health. Whether the goal is to foster secure attachment or differentiation, the result is the same: people who feel confident in their own ability to love and be loved and are able to identify and communicate their emotional needs and listen to and respond to those of their partners regardless of how anxious or threatened they each may be feeling. The interventions each model uses to take a couple from dysfunction to health vary, but the target of interventions and their intended effects will not. EFT and Bowenian therapy have been used as examples here, but areas of overlap exist across all bona-fide models of couple therapy.

So what? Finding overlap among different models may make for an interesting theoretical exercise, but does it have any practical clinical relevance? Focusing on areas of overlap allows clinicians and researchers to distill the core principles that form the foundation of couple therapy. If further developed, this could lead to a field that rests on shared principles of couple health and dysfunction, along with an appreciation for different theoretical conceptualizations and interventions that could be flexibly employed to match the worldview and stylistic preferences of specific couples. Having a field based on a core set of relational principles could greatly simplify couple therapy training and practice and streamline and accelerate couple therapy research. Most mature sciences (e.g., medicine) rest on shared principles that are gradually refined and expanded by research rather than competing models of what the field is talking about to begin with. Couple therapy can and should be no different.

Though referred to by different names, several lists of model-dependent common factors exist, some of which are quite complex (Lambert & Ogles, 2004). Karasu (1986) proposed that the goals of therapy can be distilled to three simple categories: behavioral regulation, cognitive mastery, and affective experiencing. Sprenkle and colleagues (Sprenkle & Blow, 2004; Sprenkle et al., 2009) expanded Karasu's list of common factors to include changing the doing, changing the viewing, and affective experiencing/regulation. More recently, Lebow (2014) has comprehensively described what he identified as the shared strategies across various approaches in CFT.

The distillation of model-dependent common factors of couple therapy approaches into core principles of change remains in its infancy but promises to be an exciting future direction for the field. Much of this work will be theoretical, as scholars provide a logical rationale for different models talking about the same thing. Some will be empirical, as researchers uncover core principles of relational health and distress. Gottman and others have already contributed considerably to this literature (see also Chapter 16 on the Gottman method, in this volume, by Gottman & Gottman). Some model developers have already cited these atheoretical findings as indirect empirical support for key processes of their model (see Johnson et al., Chapter 6), though these core principles will likely be found across all bona-fide couple therapy models. For example, the ability to hear a partner's point of view without becoming emotionally flooded or defensive is a predictor of a healthy marriage (see Chapter 16, Gottman & Gottman). This ability would be indicative of secure attachment in EFT, high differentiation in Bowenian therapy, the integration of split objects in object relations therapy, and the adoption of a curious stance toward one's partner and a commitment to forming a thick, rich description of their life in narrative therapy, to name a few.

THE PRACTICE OF COUPLE THERAPY

What are the model-independent common factors, and how does an understanding of them enhance couple therapy? Understanding model-independent common factors allows a couple therapist to see commonalities across different models and better adjust treatment to fit client preferences as a result. Model-independent or traditional common factors are those aspects of therapy that are inherent in the dynamics of a couple sitting in a room seeking help from a therapist. They are the "between the lines" aspects of therapy that are in play regardless of the therapist's choice of model. An understanding of traditional common factors allows couple therapists to focus their energy on the aspects of therapy that truly matter. Traditional common factors have received the most attention in the literature. The purpose of the next section is to provide an overview of traditional common factors in individual psychology, as well as discuss traditional common factors unique to couple therapy.

The Therapeutic Alliance

Out in the community, I recently ran into a former client I had seen in couple therapy. I asked him what he found most impactful about our work together. He mentioned a few of my aphorisms and metaphors that he and his partner often referred to but emphasized that the most important thing was the way I made each of them feel about themselves. He said, in essence, that as they felt better about themselves, they slowly started to see each other in a better light as well. I remembered seeing in each of them a person who was trying their best and reflecting that optimism in the way I reframed their behaviors and intent. He said it was a relief to have their efforts seen, as that helped each of them be less defensive and see their spouse as someone who was trying as hard as they were.

Similarly, a new clinician in training sought my supervision for helping a client manage his chronic pain. Pain from an accident had left him feeling depressed and lonely, and he was starting to drown these feelings in pain medication. The more the increasingly frustrated nurses tried to get him to stop abusing his medicine, the more medicine he took. Suspecting that he might be abusing medicine in part to cure his loneliness by having the nursing staff around and fussing over him, I gave the therapist some strategic therapy advice to help disrupt this cycle. The clinician returned 3 weeks later, excited that the interventions were working well. The nurses were around less because the client had cut his pain medication use down to normal amounts, and he had started developing healthier mechanisms for coping with his depression. Almost as an afterthought, she said, "But honestly, I think the main thing that helped was him knowing that I cared. Most people are just annoyed with him, and he knows that. But I really wanted to help him. I wasn't just frustrated with him—I wanted to hear his story. I mean, I still got after him a lot, but he knew it was coming from a place of sincere concern, so he took it well."

In each case, the therapeutic alliance was the "between the lines" energy that gave the interventions their potency. The interventions were helpful, but the therapeutic relationship was indispensable. Support for the therapeutic alliance as a common factor is not just anecdotal, though, as no common factor enjoys more empirical support (Sprenkle et al., 2009).

The advent of technology has led some to wonder if therapists will be replaced by artificial intelligence of some sort. A computer could, theoretically, be programmed to deliver highly empathic responses, ask intimately provocative questions, and assign relevant homework just as well as a human. But the one thing that would be missing is the knowledge that the person sitting across from you is a living, breathing human who is actively choosing to listen because they care. There is something about having one's suffering witnessed by another caring, compassionate human that transcends and amplifies the benefits of whatever knowledge or skills the other person may also impart. The therapeutic alliance is the one therapeutic ingredient that cannot be replaced by a machine.

The therapeutic alliance is particularly important in the early stages of couple therapy, accounting for as much as 22% of the variance in the overall outcome in one study (Knobloch-Fedders, Pinsof, & Mann, 2007). In therapy with mixed-sex couples, research suggests it is particularly important to form an alliance with the male, as a poor alliance with the male is more strongly associated with poor outcomes than that of the female partner (Knobloch-Fedders et al., 2007). Unique aspects of the therapeutic alliance in couple therapy are reviewed in further depth later.

Since the therapeutic alliance is a dynamic between the therapist and couple, some of it is outside of the therapist's control. Every couple therapist will have clients with whom they are a poor fit, or who are resistant to treatment no matter what the therapist does. Much of the alliance, however, is within the therapist's control and is not constrained by the variables one might think. For example, static traits such as a therapist's age, gender, personality, race, and ethnicity have not been shown to be predictive of a therapist's ability to form a therapeutic alliance (Blow, Sprenkle, & Davis, 2007). Respecting a client's desire to match some of these variables, however, can strengthen the alliance (e.g., pairing a therapist and client who share a similar age, race, or religion), as can respecting a client's cultural idiosyncrasies (Norcross & Lambert, 2018). Furthermore, experienced therapists are not better at forming a therapeutic alliance than beginning therapists (Mallinckrodt & Nelson, 1991). In some studies, first-year students have shown a better ability to form an alliance than their second-year counterparts, perhaps because second-year students, being more comfortable in therapy, are now trying hard to master techniques at the expense of the alliance, whereas having a natural ability to form an alliance is perhaps the main thing first-year students bring to the table (Stolk & Perlesz, 1990).

What is the therapeutic alliance? Many think of the alliance as simply the therapist and couple liking each other. Indeed, "bonds" are a key part of the therapeutic alliance, but according to Bordin's (1979) popular definition of the alliance, "tasks" and "goals" are equally important. "Bonds" refers to the regard in which the therapist and clients hold each other. Do they like each other? Are they matched on enough traits that they "get" each other? If so, the bond is likely to be strong—but not enough to form a complete alliance. For that to occur, a therapist and couple must also agree on the goals of therapy. Is everyone headed in the same, clearly defined direction? Last, do they all agree that the tasks of therapy—the interventions, rituals, homework and so forth—are going to help the couple reach their goals? Only when these three things are in place is the alliance thought to be complete.

Even though the alliance is most important in the early stages of treatment, it often fluctuates throughout the course of couple therapy. Perhaps the therapist inadvertently triangulates with one partner against the other, accidentally offends one partner, or any of the myriad things that can go wrong in couple therapy. Tracking the therapeutic alliance throughout the course of therapy and repairing it when necessary is important. In this regard, experience does seem to hold an advantage, as more experienced therapists have been shown to be better at evaluating the client's perception of the alliance than their less experienced colleagues (Mallinckrodt & Nelson, 1991), underscoring the idea that tracking the alliance is a skill that can be learned. Perhaps the most hopeful take-home message from this is that most therapists, regardless of experience level, are either already well equipped to establish the alliance or can be taught to become so. Suggestions for establishing and maintaining the alliance are offered later.

Hope and Expectancy

At the end of a recent session, I summarized a few central themes and told a couple that if they were able to master those things, I was optimistic about their success. The husband's eyes lit up. "That's it, Sean! 'Optimistic.' That's your golden word we cling to all week! We haven't felt optimistic in years, but we're starting to now."

The intake paperwork for this couple had included the warning that they were contemplating divorce and had tried couple therapy several times before to little success. Their friend, a respected Bay Area therapist, had given them my name for one last shot before calling it quits. Now, at the end of their second session, they were starting to feel more hope than they had in a long time. They found the interventions I was proposing relevant, and they could tell that I truly cared about them and was invested in the success of their marriage. This gave them hope that they were in the right place—that perhaps there was indeed a path out of their dilemma.

What role does hope play in walking that path? A hopeful therapist learns to amplify glimmers of light shining through a couple's bleak story. Seeing themselves through the therapist's new hopeful eyes, clients then start to see opportunities in their relationship where before they saw nothing but dead ends. As they act on these opportunities, they experience success, which in turn builds hope and confidence, which leads to more success, and the feedback loop continues. Individuals start to see the good in their partners where before they only saw flaws and ill intent. Consequently, they treat their partners better, give them the benefit of the doubt more often, and so forth. Hopeful clients take what a therapist gives them and figure out a way to make it work, whereas fewer things are more challenging than reaching a client stuck in despair.

Hope plays an important role in therapy. Much like the placebo effect in medicine, if clients expect to improve, it is more likely that they will. Many clients experience improvement between making the appointment for therapy and their first session. Once in therapy, between 56 and 71% of the variance in outcome is accounted for by work done in the early stages of treatment, presumably before clients have had much of a chance to avail themselves of many formal interventions (Howard, Lueger, Maling, & Martinovich, 1993).

What are the building blocks of hope? Davis and Piercy (2007a) found the following four variables: faith in the referral source, perception of the therapist as competent, fit of the model, and motivational beliefs and experiences. All therapy begins with a referral source, and the more persuasive that source, the more likely clients begin therapy with hope. The couple at the beginning of this section was likely more hopeful about seeking my services given that their well-respected therapist friend referred me than if they had picked me from a random, online therapist directory. It is therefore important that therapists be mindful of their public image. The way therapists present themselves in their marketing materials and website, their social media activity, their personal appearance, and their office all have an impact on perceived competence.

A strong referral source seems, initially at least, to influence clients' perceptions of their therapist's competence. Once treatment is underway, therapists maintain their competence in part by using their model to provide a viable explanation of the couple's problems and propose interventions the couple believes will help. Couples often comes into therapy exhausted and confused, having used up their capacity to fix their relationship. To experience a calm, nonanxious therapist while they pour out their anxieties about their relationship is hopeful in and of itself; it communicates that the therapist has been here before and knows what to do. It tells couples they are in the right place. This hope is compounded as the therapist says things that resonate and provide couples a compelling way out of their problems.

Of course, therapists' confidence in their abilities plays an important role in this dynamic as well. Early in graduate school, my supervisor, noticing my high client dropout rate, asked me if I believed in therapy. I said, "Yes of course!" Persistent, he asked, "Okay. Then do you believe in *your* therapy?" That was it. "Oh no, absolutely not," I replied. "I have no idea what I'm doing." He said, "I can tell," and he noted some of the ways my lack of confidence was manifesting—rambling monologues, avoiding eye contact, apologetic tone, and so forth—and suggested that was why my clients were dropping out. He challenged me to use for the next 2 weeks the solution-focused technique of acting as if I were competent, then see what happened. Annoyed at being solution-focused but nevertheless desperate for a solution, I gave it a shot—and my dropout rate lessened dramatically.

Similar to the referral source, the way therapists present themselves once therapy is underway can influence couples' hope. Beginning and ending sessions on time, being deliberate about office décor, and so forth, can all have an impact on clients' belief that they are in the right place. The list of things that impact couples' perceptions of their therapist is endless. For example, a colleague of mine noticed that when greeting a mixed-sex couple in his waiting room, if the woman shook hands first and started to lead the couple into the office, then the woman was less defensive during the initial part of the session if he allowed her to lead the trio into the office. However, if the man shook hands first, the man was more amenable to treatment if my colleague led the way into the office. Whether this idiosyncratic observation is generalizable outside of my colleague's practice is not the point; the point is that carefully observing all of the small things that impact a couple's experience with the therapist will go a long way toward how hopeful they are that they are in the right place.

Davis and Piercy (2007a) found that a client's motivational beliefs were another important part of hope. Couple therapy is often a long, circuitous journey, during which progress can feel slow, the finish line vague, and the hope tested. Trusting the referral source, the therapist and the model facilitate hope. Motivational beliefs provide the "why" to justify the hard work of therapy. If the client already possessed hopeful beliefs prior to therapy (e.g., "We are here to work hard at the marriage so we can provide a better upbringing for our children than we enjoyed"), then the therapist can help maintain hope by underscoring these motivating factors throughout therapy. If a client has a hard time identifying a "why" for doing couple therapy, identifying a few at the outset to draw on when couple therapy gets difficult is a wise idea. A therapist can provide motivating beliefs in the form of a reframe. For example, Davis and Piercy found that participants found motivation in the notion that each partner was playing a role in the problem, and if they didn't figure out that role in this marriage, they might end up repeating the same problems in their next relationship, so they might as well try to figure it out now.

It is common in couple therapy for each partner to have disparate levels of hope. This is often ameliorated as a therapist empathizes with and addresses whatever is lowering the hope of one partner while simultaneously maintaining the hope of the other partner. This is usually accomplished by the methods outlined earlier. In some cases, however, the thing providing hope to one is what is demoralizing to the other. The husband of a couple I saw had recently decided to leave the religion of his and his wife's youth. The religion's teachings about marriage were what gave the wife hope that things would work out, whereas the husband now viewed the religion as a source of disillusionment and pain. In this and similar cases, special care must be taken to empathize with each partner in a way that allows them to feel understood without alienating the other partner. A therapist's personal opinions must be kept in careful check. Using words, tone and a balance of time that does not give validity to one viewpoint over another is crucial. Regardless of how aligned with hope partners are, however, carefully monitoring their hope and remoralizing as needed remains an important common factor of successful couple therapy.

Extratherapeutic and Client Factors

After the first session with Suzanne and Ricky, I thought counseling would proceed as usual. There were no betrayals or significant attachment injuries, and each seemed capable, bright, and willing to do whatever it took to get their 14-year marriage back on track. Their marriage had always been strong until 2 years earlier, when their oldest daughter was diagnosed with a serious health condition that would require 5-hour round trips twice a week, indefinitely, to visit a specialist. Her prognosis was unclear, treatment was expensive, and stress was high. They felt stretched past their breaking point, and their marriage had understandably started to suffer.

Suzanne and Ricky worked hard in therapy and showed improvement, but despite our best efforts, progress plateaued after a few months. I tried everything I had. I had considered referring them to a colleague when a change in health insurance allowed them to see a specialist 20 minutes from their home. Almost immediately, a huge weight was lifted from their shoulders. Even though their daughter's prognosis was still unclear, their moods lifted, and their marital satisfaction improved significantly. They applied some of the things learned in therapy, but we all agreed that the shift in their weekly travel routine was what helped the most. The stress of their situation had simply been more than they could handle, and once the stress eased, they were better able to use their existing resources and abilities to their benefit.

Suzanne and Ricky's situation illustrates a truth that makes sense but rarely receives attention in the literature: Sometimes what clients truly need is outside the reach of therapy (Lambert, 1992). Moving, changing jobs, or financial improvements are all examples of extratherapeutic factors that can influence clients' well-being as much or more than therapy.

Awareness of this fact can allow clients and therapist to address environmental stressors as much as possible while simultaneously releasing themselves from feeling responsible for those that are out of their control.

Of course, this is not to say that couples' internal coping skills have no bearing on their lives or cannot be improved in therapy. Therapy does work, but the extent to which it works depends largely on how much the client works. Perhaps it goes without saying that the couple is the most important common factor, extratherapeutic or otherwise. The partners are, after all, the people who are applying what they have learned in therapy. Furthermore, people were overcoming significant challenges on their own long before therapy was around. In their excellent chapter on the topic, Tallman and Bohart (1999) note:

> The client's capacity for self-healing is the most potent common factor in psychotherapy. It is the "engine" that makes therapy work. . . . Therapy facilitates naturally occurring healing aspects of clients' lives. Therapists function as support systems and resource providers. . . . We argue that the most parsimonious explanation for the dodo bird verdict is that it is the client, not the therapist or technique, that makes therapy work. (p. 91)

Tallman and Bohart go on to draw an analogy with physical fitness, asking what matters more—that a person uses a stair-climber or a treadmill, or that they got themselves off the couch and down to the gym to begin with?

So it is with different models of therapy. Does it matter more that couples use cognitive-behavioral therapy or EFT to find harmony in their relationship, or that they show up and do the work? Clients' problems (that are in their control) usually continue to grow as they abdicate responsibility for solving them, whereas other clients overcome seemingly insurmountable obstacles by putting therapy to use.

If clients are the most important variable in therapy, does therapy even matter? Yes, it does. Remember that the therapist is largely responsible for facilitating a process and providing a structure wherein the partners can have a new experience with each other. But once that process is in place, it is the couple that makes use of it, sometimes in ways other than the therapist intended. This is not out of rebellion but because the partners were able to creatively apply the information despite the therapist missing the mark. Couples' creativity often saves the day, which likely happens more often than therapists acknowledge.

What are therapists supposed to do with the knowledge that couples themselves are the most important ingredient of therapy? Many systemic models (e.g., solution-focused, strategic, narrative) wisely privilege clients' experience and wisdom, and assume that clients will self-heal given the right environment (e.g., EFT, collaborative language approaches). Couple therapists should maximize these processes. Regardless of the model used, however, a couple therapist should assume that couples are capable of solving their problems given the right circumstance. For example, viewing a partner's problematic behavior as an attempt to solve a problem rather than simply being a jerk allows the therapist to support the partner with guidance rather than punishing with condemnation and moralizing. Viewing partners as capable of solving their problems allows the therapist to maintain hope when they are demoralized. Furthermore, if partners will self-heal given the right environment, a couple therapist's first and foremost expertise becomes that of a process consultant rather than a content expert—a distinction many couple therapists find freeing.

Therapist Factors

A professor in my master's program was a particularly powerful therapist. People came from far and wide seeking her services, and her insights were legendary. I was fortunate to have her as a supervisor early in my program. She began individual supervision with me one day by asking how I was doing. "Good," I said. Things were going well. She looked at me for a while, her brow gently furrowed in concentration. "No, Sean. How are you doing?" she asked more carefully. I looked at her, my lip started to quiver, and I burst into tears as stresses I was not even aware of came pouring out. After what seemed like just a few minutes but was likely much longer I collected myself and thanked her for asking. I felt great!

Thinking I had just experienced some tool from her vast clinical repertoire, I asked her to show me how to do what she had just done. "I'm not sure what you mean, Sean. I just noticed you seemed heavy, so I asked how you were doing." Convinced there was more to it than that, I continued to press for a more concrete answer throughout the semester. Perhaps sensing my persistence, she finally relented and told me, "Sean, the reason I haven't answered is because you're asking the wrong question. 'Therapeutic' isn't something you *do*, it's something you *are*."

When most of us choose a therapist for a friend or family member, we choose a therapist based on their personal traits rather than trainings received or skills mastered. The humanistic person-centered theory of Carl Rogers suggests that humans' deepest desire is to be understood and accepted. We are therefore drawn to therapists who seem best able to provide this understanding and know that this has more to do with the therapist's traits than with credentials or certifications.

Rogers believed that people have an innate desire to grow and improve, but that desire gets thwarted as we try to measure up to distorted conditions of worth placed on us by imperfect parents and society. However, given an environment characterized by unconditional positive regard—a deep acceptance of people as they are—a person experiences the support necessary to shed previous conditioning and live a more authentic life. Establishing this environment is the main goal of the Rogerian approach, and doing so requires the therapist traits of empathy, positive regard, and congruence. Empathy involves a therapist's ability to see completely through the client's eyes—to know how they see the world, and what it feels like to see the world that way (Rogers, 1957).

Rogers (1957) described his second core component of positive regard:

> To the extent that the therapist finds [themselves] experiencing a warm acceptance of each aspect of the client's experience as being part of the client, [they are] experiencing unconditional positive regard. . . . It means there are no conditions of acceptance. . . . It means prizing of the person. . . . It means caring for the client as a separate person. (p. 101)

Nonpossessive warmth is also an aspect of positive regard. Unconditional positive regard is sometimes misconstrued as a blanket, amoral acceptance of anything a client is doing. "Positive regard" refers more to how a therapist feels about a client than it does to adopting a *laissez-faire* stance toward their life choices. Acceptance, as Rogers meant it, does not mean all client behavior automatically gets the therapist's stamp of approval, but rather that the therapist values the client as a person and sees the world through their eyes no matter what they are doing. In other words, the murderer would likely experience a more challenging therapeutic environment than would Mother Teresa, but they would each know that their Rogerian therapist truly cared about them, deeply understood what they were going through, and saw them as equally worthy of love.

Rogers's third component of an effective therapist is congruence (Rogers, 1957). Since a main goal of Rogerian therapy is to help a client live an authentic, congruent life, it follows that a therapist is taking the lead by doing the same, especially in the therapeutic relationship. Congruent therapists are deeply and freely themselves. There is no disconnect between what they are thinking, feeling, and expressing in the therapeutic relationship. Being congruent in every aspect of life is a lifetime goal that few achieve, but Rogers suggested that being congruent in the therapeutic relationship is both possible and necessary.

Rogers's specific model of therapy faded in importance after his death, but these ideas continue to inform the core of several contemporary couple therapy models, including emotion-focused, postmodern, collaborative, and experiential approaches. Recently in couple therapy, Stephen Fife and colleagues have described the therapeutic pyramid metamodel, which underscores the importance of what they call a therapist's I–Thou way of being (Davis, Fife, Whiting, & Bradford, 2020; Fife, Whiting, Bradford, & Davis, 2014). Empirical support for this model is indirect, though direct empirical support is beginning to accumulate (Holyoak, Fife, & Hertlein, 2020).

The therapeutic pyramid outlines a hierarchical relationship among three common factors: skills and techniques, the therapeutic alliance, and the therapist's I–Thou way of being. The success of each layer of the pyramid rests on the strength of the immediately underlying layer. Skills and techniques occupy the smallest, topmost layer of the pyramid, indicating their minor importance relative to the other two underlying layers. If skills and techniques are not working, clinicians are encouraged to look at the next underlying layer of the pyramid, which is the therapeutic alliance. Even the most perfectly executed skills and techniques are likely to fall flat absent the trust and caring of a healthy therapeutic alliance. But what if the therapist is not successful at addressing a broken therapeutic alliance? In this case, clinicians are urged to examine the bottom layer of the pyramid, their way of being (Davis et al., 2020; Fife et al., 2014).

Philosopher Martin Buber (1958) claimed that people are constantly fluctuating between two ways of being: I–It and I–Thou. A person in an I-It way of being views others as objects whose existence is either a help or a hindrance. If the other can offer some benefit, then the observer wants more of the other in their life, whereas the opposite is true if the other is viewed as a hindrance. Either way, the other will sense at some level that they are being objectified and will pull away, physically or emotionally, from the observer. Extreme examples of an I–It mindset are easy to summon in today's polarized society. For therapists, more benign yet ubiquitous examples of an I–It mindset could include only liking clients whose praise and progress helps you feel competent; refusing to work with certain populations with whom you disagree or working with them with the underlying motive of making them more like you; withholding clinical insights, the disclosure of which would make you uncomfortable, so you start to feel resentful of certain clients or hope they do not show up, and so forth. The examples are myriad. Clinically, an I-It mindset is problematic, in that clients can tell at some level that they are being objectified. They may drop out of treatment, or if they continue, they will likely withhold the deeper vulnerabilities that are key to their progress. Or, more tragically, more vulnerable clients might leave therapy blaming themselves for being subtly rejected. After all, things must be really bad if even your therapist rejects you!

Conversely, persons with an I–Thou mindset view the reality of the other as being as important as their own. They see their well-being as being inextricably connected to the well-being of other people and conduct their relationships accordingly. Their interactions reflect an empathic reverence for the hopes, dreams, triumphs, and tragedies of the other. When a therapist views clients through an I–Thou lens, clients feel seen and valued. Challenges can be delivered without offense because clients trust that the therapist truly cares. Clients are also more likely to be open to the therapists' interventions, forgiving of their mistakes, and committed to the hard work therapy requires.

People are rarely exclusively in either mindset. Most people are more I–Thou with some people and I–It with others, with the balance fluctuating throughout life or various phases of a relationship. Therapy can likely still be productive while a therapist is in a mild I–It mindset, but the deepest, most healing work occurs when a therapist sincerely feels an intense regard and respect for their client's shared humanity (Davis et al., 2020; Fife et al., 2014). In this way, an I–Thou mindset forms the foundation of the therapeutic alliance, which in turn makes a therapist's interventions more effective. Which, again, is a more complicated way of saying that "therapeutic" is not something you *do*, it is something you *are*.

The therapist is likely one of the most impactful yet understudied of the common factors. Though the therapist conservatively has been shown to account for only 6–9% of the outcome variance in psychotherapy, it is nevertheless an important contribution; if this statistic were expressed as a correlation coefficient it would be between .24 and .30 (Wampold & Imel, 2015). Blatt, Sanislow, Zuroff, and Pilkonis (1996), in their secondary analysis of the landmark National Institutes of Mental Health study on depression, which found little difference between treatments, noted that the most variance in outcome existed among different therapists. Notably, the most effective therapist in the entire study was a psychiatrist who was instructed not to do therapy at all, but rather to simply be supportive while reviewing her client's medicine.

Despite knowing that therapist attributes are important, we know far more about what does not contribute to an effective therapist than what does. Static traits such as gender, race, and age as well as variables such as years of experience, degree earned, and model practiced have little to do with outcome (Blow et al., 2007). What seems to matter more is a therapist's ability to fashion interventions in a way that respects a client's personality, worldview, and culture (Johnson & Talitman, 1997); establish a highly structured session for reactive clients and a looser session for less reactive clients (Lebow, 2006); and routinely gather client feedback and adjust their approach accordingly (Sparks, Kisler, Adams, & Blumen, 2011). Similarly, the "allegiance effect"—the tendency for a study's results to favor the theoretical allegiance of the researcher—suggests that if a therapist believes in the power of their approach, they are more likely to be effective (Blow, Sprenkle, & Davis, 2007). The good news is all of the therapist variables that have been shown to be related to outcome are within the therapist's control.

Common Factors Unique to Couple Therapy

Most, if not all, of the common factors of individual psychotherapy apply equally to couple therapy. The complex nature of systemic therapy led Sprenkle and colleagues (Sprenkle & Blow, 2004; Sprenkle et al., 2009) to propose four additional common factors unique to CFT: (1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance.

Conceptualizing Difficulties in Relational Terms

Systemic conceptualization of problems—that is, viewing symptoms as adaptive responses that both maintain and are maintained by one's environment—is a hallmark of couple therapy. If Pedro is depressed, a systemic therapist would pay attention to Pedro's biology (e.g., sleep, health) as well as his intrapsychic processes (e.g., irrational beliefs) as much as a linearly oriented psychologist would. More importantly, however, a systemic couple therapist would view Pedro's depression as a response to his various systemic contexts, including his romantic and family relationships, work relationships, sociocultural position, and so forth. Regardless of the model employed, a systemic therapist would emphasize empowering Pedro to influence his various systems to his benefit as much as possible, on the assumption that once his systems support his mental health, his mental health is more likely to follow. Intrapsychic and biological work would be seen as adjunctive to this larger goal.

Sprenkle and colleagues (2009) view systemic conceptualization as a common factor that makes couple therapy uniquely effective with relationally based problems. That a rebellious teen would benefit more from improving communication in family therapy than time on the couch undergoing psychoanalysis may seem obvious. A meta-analysis by Shadish and Baldwin (2003) found support for this claim, noting that couple therapy had an effect size of .84, indicating that couples who sought couple therapy were better off than approximately 80% of those that did not.

Disrupting Dysfunctional Relational Patterns

If conceptualizing difficulties systemically is a common factor of couple therapy, it follows that disrupting those same patterns is as well. Is a husband's withdrawing because of his wife's pursuing, or vice versa? Systemically speaking, all interaction occurs in a feedback loop, in which each person's response both shapes and is shaped by their partner's response. Feedback loops are a foundational part of most systemic approaches. EFT focuses on altering how people feel during these problematic cycles (see also Chapter 6, in this volume, by Johnson et al.); cognitive-behavioral couple therapy focuses on altering a couple's thoughts and behavior (see also Chapter 3, in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade). The list goes on. While the focus of entry into a feedback loop may vary, all empirically supported systemic therapies focus on disrupting these feedback loops (Davis & Piercy, 2007b).

Expanding the Direct Treatment System

Generally speaking, systemic therapists prefer to involve as many people as possible in treatment. Doing so has many benefits that include gaining a broader perspective on the problem, helping key people in the couple's life support their progress, and having their support network present for important breakthroughs (Pinsof et al., 2018). As with the previous two common factors, most of the empirically supported systemic approaches expand the direct treatment system.

For example, Tariq painted a dire picture of his marriage, and of his wife Akhila in particular. After four sessions with Tariq, I was convinced he was trapped in a loveless marriage with a relentless taskmaster. Wanting to check this assumption, I invited Akhila to our next session. Sure enough, Tariq's portrayal was incomplete. Akhila was on Tariq's case a lot, but it was easy to see her nagging as a protest against his seeming indifference toward her—something I did not see with Tariq, who instead showed me the deep distress underneath his cool exterior at home. Involving Akhila changed the course of therapy from validating Tariq's sense of victimhood (which can often lead to divorce) to empowering each of them to improve their marriage. When that work plateaued, we invited Akhila's parents—who had recently moved in with Akhila and Tariq, causing a lot of marital tension—in for a few sessions to clarify boundaries between the couples and help establish culturally sensitive ground rules for the home. Each of these expansions of the direct treatment system added a layer of support that solidified the gains made in therapy.

Expanding the Therapeutic Alliance

As previously mentioned, the therapeutic alliance is the most empirically supported common factor (Asay & Lambert, 1999). The more people in the room, however, the more complex it becomes to maintain the therapeutic alliance. Careful listening and validation are still necessary, but unless balanced equally across all parties, what joins with one can alienate another. The artful balancing of the therapeutic alliance in couple therapy, where people are by definition not seeing eye to eye, is a common factor unique to couple therapy. Sprenkle, Blow, and Dickey (1999) recommended the following considerations when managing the expanded therapeutic alliance: (1) tracking the alliance, (2) joining behaviors, (3) managing split alliances, and (4) assertive engagement.

TRACKING THE ALLIANCE

There are three different sessions going on at the same time in couple therapy—one experienced by the therapist, and one each of the partners. Therapists commonly overestimate the strength of the alliance, which can lead to dropout if the gap between the therapist's and partners' perceptions becomes too wide. For this reason, tracking the alliance is critical. At minimum, a therapist can ask about the alliance and observe the couple's reactions. Alternatively, the alliance can be tracked using an objective measure. Several such measures exist, including Duncan and Miller's simple measures (Miller, Duncan, Sorrell, & Brown, 2005), whose brevity makes them easy to administer but less statistically reliable. Pinsof's self-report alliance scales measure the strength of the alliance relative to tasks, bonds, and goals, as well as the felt sense of the connection between the therapist and each family member, the family and the therapist, and the family members themselves (Pinsof & Catherall, 1986). These scales take more time to administer and score but have good statistical reliability. Last, the most thorough (and therefore statistically reliable yet time-consuming to administer and score) are the couple and family scales from the Systemic Inventory of Change (Knobloch-Fedders, Pinsof, & Mann, 2004). Therapists can also easily develop their own measures.

JOINING BEHAVIORS

Joining with each family member has long been a hallmark of couple therapy. Joining includes matching a family's language and style of presenting while still remaining true to one's clinical identity. As previously mentioned, therapists need not share a couple's race, ethnicity, age, or socioeconomic background to join effectively, but they do need to have an awareness of and show respect for couples' cultural contexts. Listening carefully, helping couples see their relationship differently, and encouraging realistic optimism about treatment success can also help the joining process (Sprenkle et al., 2009). There may be as many ways to join as there are couples; the principle is that joining needs to be a primary focus of therapy, especially during the initial sessions.

MANAGING THE SPLIT ALLIANCE

Couples often come to therapy with disparate levels of investment in therapy or in the relationship itself. In these cases, it is natural to join easily with the more invested partner, thus forming a split alliance. Split alliances can also form as therapy progresses and the therapist forms a closer bond with one partner. A therapist often has more in common with one partner than the other or may find it is simply easier to get along with one partner. Self-of-the-therapist issues may also be a factor, as therapists fall into the role they played as a child with couples who represent their parent(s) in some way. However they form, split alliances are a threat to couple therapy, and navigating them requires a good deal of skill.

Less-invested partners are often more detached simply because they do not believe their inner experience will be valued in therapy. Therefore, most split alliances can be repaired by simply ensuring that each partner is deeply heard and understood. Once detached partners realize their experience will be given an equal voice in therapy, they often reengage. Ideally, the process of listening and validating occurs by devoting roughly equal amounts of time to each partner. In cases of a split alliance, however, this is often not possible—the more detached partner often requires more attention (Sprenkle et al., 2009). This poses a potential threat, in that the more invested partner may tire of the imbalance and become disengaged. This dilemma can be circumvented by having an individual session with each partner, even though most of the need for that session is for the detached partner. When this dynamic occurs in conjoint sessions, the therapist should pay close attention to the more invested partner's tolerance of the imbalance. Use of the previously mentioned end-of-session alliance measures can aid in this, though during the session, good old-fashioned intuition is often the best guide. Therapists should also ensure that they are not unwittingly playing into a dynamic in which the less-invested partner maintains control of therapy and the relationship by being more detached.

It should be noted that validating a partner does not mean agreeing with them. Agreeing with one partner's version of events over another's will almost certainly lead to a split alliance, and clients are often on the lookout for this occurring. When reflecting back on one person's statements, it is helpful to use tentative qualifiers that allow each partner to have their own reality, such as "So, for you it was like . . . " or "You experienced it this way . . . " rather than absolutes, which imply one person is right and the other is wrong (e.g., "Oh, so that isn't what happened at all . . . " or "You didn't do that, right?"

That said, it is important to be genuine with a couple. If one partner's reality seems particularly distorted, it is important to not empathize so much that your validation is mistaken for condoning a problematic story or behavior. Clients often terminate treatment with a therapist's seeming validation of one partner's distorted reality ringing in their ears, becoming an eternal truth that often benefits one at the expense of the other. I made this mistake early in my training by overempathizing with an aggressive, intimidating husband. As soon as he felt like I was condoning his point, they terminated therapy. The wife later resumed treatment with a different therapist at the university clinic and reported that her husband now felt justified in continuing his abusive ways because of his experience in therapy. In short, if a behavior is problematic it needs to be highlighted as such, though one must pay careful attention to one's approach when doing so both to preserve the alliance and maintain one's clinical integrity. In my experience, few things can harm an alliance more than waiting too long (or simply failing) to express a clinical concern.

ASSERTIVE ENGAGEMENT

In individual therapy, client engagement is usually at least minimally ensured given that the client initiated contact. In couple therapy, however, one partner often either does not want to participate or was not invited to do so. "Assertive engagement" is a term coined by Santisteban and Szapocznik (1994) to describe the process of actively reaching out to absent parties to encourage their participation in treatment. They noted that engagement in therapy increased by 55% when using an assertive engagement approach compared to their standard intake procedure. The most straightforward form of assertive engagement is simply reaching out and asking for partners' participation. If a partner is afraid of being unfairly targeted in couple therapy, participation can be framed as needing to gain as many perspectives on their spouse as possible. Then, if the alliance is strengthened after a session or two, the partner can be invited to participate fully.

MECHANISMS OF CHANGE

To clarify and reiterate, the common factors themselves are the curative factors of therapy regardless of the model used to employ them. Rather than models being primarily responsible for change, the interaction among myriad common factors (of which a coherent model is one) is responsible for change. Models are words on paper and, as such, are not effective in and of themselves. The ideas of the models either come alive or die in interactions between the partners and their therapist (Sprenkle et al., 2007). For example, a client's hope is influenced by the strength of the alliance, specifically, whether the therapist is saying things that resonate; is empathetic, congruent, and confident; and offers interventions the client sees as plausible. The therapist in turn has confidence in the approach in part because of the guidance provided by the model. Every common factor is intertwined with the others.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

For decades, randomized clinical trials (RCTs) were (and often still are) considered the "gold standard" for establishing treatment efficacy. Findings from RCTs in both individual and couple therapy consistently demonstrate that therapy works and works well (Asay & Lambert, 1999). A major problem with RCTs, however, is that they usually only compare the model being tested against treatment as usual or wait-list control groups rather than other bona-fide models. Perhaps not surprisingly, most tested models are demonstrated to be effective in these scenarios. This is helpful in showing that a particular type of therapy works, but it is not helpful in determining why it works, under what circumstances it works, or whether it works better than other models.

Meta-analytic reviews address this problem by comparing the findings of RCTs relative to each other. Smith and colleagues' (1980) landmark meta-analysis yielded a finding that was initially jarring but has become widely accepted the more it has been replicated: Therapy works and works well, but no single model works better than another. This is especially true when researchers control for confounding variables such as researcher allegiance (Wampold & Imel, 2015). There are several possible explanations for this finding. Perhaps different models employ different yet equally effective change mechanisms. Or perhaps there are differences, but meta-analysis is too blunt an instrument to discern these differences. Similarly, perhaps different approaches work better for different couples, but this finding is masked by group treatment effects. The most popular explanation, however, has been that the common factors outlined in this chapter are largely responsible for change.

The finding that couple therapy works is well established (Bradbury & Bodenmann, 2020). We know far less, however, about *why* couple therapy works. "Process research," which measures the effects that the presence or absence of certain therapeutic processes have on the outcome of therapy, is the most promising methodology for answering this question. Process research can lend insight into potential conceptual overlap among models. For example, couple therapy RCTs that incorporate process research have shown that the softening of emotional expressiveness and responsiveness in EFT (see Chapter 6, in this volume, by Johnson et al.) and communication, behavior change in target problems, and acceptance of target problems in integrative and traditional behavioral couple therapies (see Chapter 4, "Integrative Behavioral Couple Therapy," also in this volume, by Christensen, Dimidjian, Martell, & Doss) are associated with positive outcomes. A closer look at each of these concepts reveals a good deal of conceptual overlap.

Process research can also shed light on which processes are more important at different stages of therapy with different presenting problems, and which models are better at facilitating those processes than others. For example, in the early stages of recovering from an affair, rebuilding trust and emotional safety is particularly important. It is likely that certain models provide better guidance on navigating that stage than others. Later, once trust has been established, the focus might shift to building new routines and traditions that can buttress against the future erosion of trust or risk of another affair. Different models might be better suited for this task than were suited for the initial establishment of emotional safety (see Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder).

Such a shift in research focus could greatly change the way therapy is practiced and taught. Rather than emphasizing models, the emphasis would be on understanding the relevant processes or principles at play in different stages of therapy with different presenting problems. Models (or components of models) would be selected for their ability to facilitate these processes and could vary based on client feedback and as the needs of treatment change. The focus would be on using client feedback to learn what works in the moment rather than forcing a client to fit a model (Blow et al., 2007). Prochaska's popular approach to substance abuse treatment follows this pattern by pairing a particular model of therapy with a client's "stage of change"—a well-established common factor (Prochaska & Norcross, 2009). Snyder (1999), Benson and colleagues (2012), Lebow (2014), and Pinsof and colleagues (2018) have each proposed common factors—informed, principle-based approaches to couple therapy based on this logic. These and similar approaches are empirically informed, intentionally maximize the effect of common factors, use bona-fide models, and are client driven. Approaches such as these are likely to be the future of couple and family therapy training, practice, and research. An example of a couple treated using such an approach concludes this chapter.

What Does It Mean to Be a Common-Factors-Informed Couple Therapist?

It may be helpful to describe what it does and does not mean to be a common-factors-informed couple therapist (Davis & Hsieh, 2019). I often hear people say they are common-factors therapists, yet when pressed, they are not exactly sure what that means. Many say it means they prioritize the therapeutic alliance at the expense of adhering to a model. This is misguided, however, as the use of a model is a common factor in and of itself, and the tasks prescribed by the model are an important part of the alliance. Others say it means they gather client feedback about progress and adapt their approach accordingly. This is in keeping with a common-factors paradigm but also incomplete.

Confusion over what it means to be a common-factors couple therapist is understandable, since common factors are not a model per se, but rather a metamodel or model of models. One would not be exclusively a common-factors couple therapist like one might be an EFT or cognitive-behavioral couple therapist, for example. Since there is no such thing as a pure common-factors approach, Davis and Hsieh (2019) recommend using the term "common-factors-informed" couple therapist to denote a practice that deliberately focuses on common factors regardless of the model employed.

If two people are practicing from the same model but one is common-factors informed and the other is not, how will their work contrast? Since common factors are at play in all effective couple therapies, is everything technically a common-factors approach? If so, why even discuss common factors? If not, what, if anything, is a common-factors approach? The answer is "yes" and "no." Yes, there are common factors throughout all effective therapies, but that does not mean that a therapist practicing from a particular model is necessarily maximizing the potent contributions of the common factors. Doing so requires a deliberate focus on several core common-factors principles. Defining the principles of common-factors-informed practice allows an observer to distinguish between common-factors-informed couple therapists and their counterparts, even if they are using the same model.

Davis and Hsieh (2019) outline the following six core principles that define the practice of common-factors-informed couple therapists: (1) seeing overlap among theories (i.e., so if an approach is not working, they can remain focused on the same principle but employ a different, more palatable theoretical approach); (2) passionate about theory, not *a* theory (i.e., so they have a wide variety of theoretical approaches in their repertoires should a couple's needs dictate a change in course); (3) client-centered (i.e., empowering partners' agency and regularly adapting their approach based on the partners' feedback); (4) monitoring hope and the therapeutic alliance; (5) views members of a couple as people rather than objects; and (6) prioritizes healing over therapy (i.e., humbly encouraging couples to engage with as many of their healing contexts as possible). The following case study illustrates these principles in action.

CASE ILLUSTRATION

Robert and Gladys were referred to me in the most interesting of ways: Robert picked up his iPhone and asked Siri who they should see for marriage counseling in Roseville, California. Robert told me that Siri replied, "Sean Davis. Would you like me to call him?" I was not seeing new couples at the time, but who was I to argue with Siri? I am glad I agreed to see Robert and Gladys, as I enjoyed my work with them.

Robert and Gladys, a retired couple, had been forced to relocate to Roseville due to their home being destroyed. One morning, Robert woke up to orange, smoky skies and the smell of fire. Fires are not unusual in Northern California, so at first he ignored it, but a frantic announcement over the loudspeaker of a racing police car confirmed his fears. This time was different—they needed to evacuate right away. Robert woke Gladys up and broke the news. Gladys's mobility is compromised, but she nevertheless roused her elderly father (who was living with them) and ushered him and their pets into their car, while Robert scrambled to load their important belongings. Within minutes, they joined a long line of bumper-to-bumper traffic trying to escape the inferno that was roaring all around them.

Needless to say, it was a traumatic time for Robert and Gladys. They arrived in Roseville disoriented and in shock. Both were in excellent physical and cognitive health (aside from Gladys's compromised mobility), and had adequate financial reserves, so they were able to quickly secure a rental home while they figured out their next move. This was proving difficult, however, as their insurance company and federal disaster relief kept deflecting responsibility for financial assistance back and forth between each other. Robert and Gladys had a happy marriage, but the posttraumatic stress from the fire, combined with their inability to start putting their life back together, had them so flooded with their own emotions that they were scarcely able to attend to those of their partner. They both felt overwhelmed, helpless, and had started bickering frequently. It was at that point that they called me.

I prefer using EFT with couples unless client needs dictate otherwise, so I began therapy with Robert and Gladys the same way as with any other couple—listening to their story, tracking their interactional cycle, and helping them start to access and express their primary emotions. By the middle of the second session, however, it became apparent that they were so emotionally flooded from their life being in upheaval that we would have to address those needs first, before they could benefit from EFT. Consistent with the sixth principle (discussed earlier), my priority shifted to helping them restore a sense of order and control to their lives by connecting them with local groups and resources. In this regard, I functioned more as a social worker than a couple therapist.

Prior to the fire, Gladys had enjoyed a rich social life and was suffering from being stuck at home all day. Fortunately, there was a local community group for people with Gladys's disability, which she started enjoying. Robert was preoccupied with figuring out their insurance so they could decide where to live—he wanted badly to settle down again. Suspecting that Robert was too emotionally flooded to navigate the maze of insurances effectively, I had them sign a release of information and spoke with their lawyer as needed to help them problem-solve. I also gave them a list of local restaurants serving their favorite food, showed them where the trails were near their home for walking their dogs, and helped them get in touch with various social programs as the need arose.

Restoring some order to the lives of Robert and Gladys started to alleviate their anxiety and despair. They instinctively wanted to put their lives back together but did not know where to start—now they did. Consistent with the fourth principle, pointing them in the right direction (then stepping back once they got going, so as to not undermine their adaptive desire for self-determination) gave them hope that they could rebuild a life they enjoyed.

Once their temporal needs were on track, I resumed EFT. This time, however, I found that in addition to wanting to improve their marriage, they wanted to grieve the loss of their house—a dream home they had designed and built over the course of their decades-long marriage. It was dawning on them that they simply did not have the energy to undertake a project like that and settling into a cookie-cutter home in suburbia felt like a heavy loss. They were too scared to build on their burned lot again. They felt stuck. Grieving the loss of their house and deciding their next move was intentionally woven throughout their couple work over the next several months. I figured that the more they achieved peace with this loss, the more settled they would feel, the more their posttraumatic stress disorder (PTSD) would subside, and, consistent with the third principle, the more they would bounce back to their previously happy marriage.

As they began to come to terms with the loss of their house, I shifted focus to finding a vision for their future that would excite them. This was easier for the socialite, Gladys, whose identity had been centered more around relationships, than it was for reclusive engineer, Robert, whose identity had been around building things. Gladys was feeling emotionally "full" enough from her new friends that she was better able to listen to Robert's sorrow without getting defensive, so I started to gradually coach Gladys on helping Robert hold his grief. Robert was not yet at the point where he could do the same for Gladys, so, for a while, therapy was likely to be lopsided—Gladys supporting an often-grumpy Robert.

This was a gamble. On the one hand, as with all my couples, I wanted Gladys and Robert to become self-sufficient in their communication. Having the readier spouse start that process is my normal approach. On the other hand, I suspected this might present a problem for the therapeutic alliance, as I did not want Gladys's needs to be forgotten or for her to feel unfairly burdened. I cared deeply about both of them, and they knew it (consistent with the fifth principle), but I "clicked" slightly more with Robert. I always assume couples can ascertain when I naturally get along with one more than the other, so I try to balance the session so as not to reflect that bias. Nevertheless, I always assume I am not as good at that as I think, so I regularly check in about the alliance when this is the case. I also did not want to subtly reinforce gender norms suggesting that the man could do whatever he wanted while his wife picked up the pieces. This did not seem like a big risk, as Robert and Gladys were pretty progressive, but it was still on my radar. This sensitivity and tracking of potential threats to the alliance is consistent with the fourth principle.

Ultimately, the risk paid off. For the most part, Gladys was a good sport with this new dynamic—until I made a mistake. Gladys had called with an urgent request from their lawyer. I was out of the country at the time, and due to a miscommunication with my assistant when I returned, I mistakenly thought the situation had been handled, so I did not call them back. Robert then called me, at which point I realized the mistake and got them the paperwork they needed. I was busy playing catch-up from being out of town and missed the potential significance this miscommunication had for the alliance. As far as Gladys and Robert knew, I'd simply ignored Gladys but responded to Robert. Sure enough, Gladys did not show up for the next appointment. Robert confirmed she was feeling alienated. I called Gladys, explained what happened and apologized, and invited her to come in for a session free-of-charge to balance out Robert's individual session and make up for my mistake. She was relieved to hear the sincerity in my voice. She turned down the free individual session, returned for the next couple session, and we picked up where we had left off.

The alliance remained strong throughout therapy. I believe it was the main thing that contributed to their success. A therapist in my group once mentioned that she always loved seeing them in the waiting room because she knew she was going to hear an hour of laughter coming from my office. We genuinely liked each other, and, consistent with the fifth principle, this positive regard was keeping them engaged with therapy and improving.

Gladys was responding well to therapy. Her open, social demeanor lent itself well to the affective processing of EFT. Her social network was also helping, and in an unexpected twist of fate, the nature of her disability had ended up shielding her from some of the more traumatic aspects of the fire. She was starting to sleep better, get startled less, and talk about her time in her previous home without becoming dysregulated. She was becoming optimistic about their future and had stopped provoking fights with Robert.

Robert, however, was not doing as well. He continued to remain relatively isolated, would perseverate over the injustice of unresolvable issues with their insurance, and despite his usually cheerful, optimistic demeanor, was becoming increasingly short-tempered with Gladys. He knew he was struggling and needed more help. Realizing that his PTSD might require specialized treatment, I referred Robert to a trauma specialist within my group practice, and we paused marriage counseling. Robert benefited from having therapy focus just on himself, and after about 2 months, Robert and his therapist agreed it would be a good time to resume couple therapy.

Robert was indeed better able to regulate his emotions, so I resumed EFT. Robert responded poorly, however, becoming resistant to "all this touchy-feely stuff." This remained true despite trying EFT from several different angles, some more cognitive than others. It seemed we had reached the end of what EFT could offer—or at least my EFT. Since their marriage was strong prior to the fire, with no attachment wounds to repair or chronic problematic cycles of communication to alter, maybe EFT had given all it could. EFT helps people better support each other emotionally, which they were. But Robert had hit a wall.

My main goal with using EFT was to get Robert to open up and let his wife in to help carry his emotional burdens. But Robert was not really that kind of guy, at least in the aftermath of the trauma. I grew up around men like Robert and understood how they work. Talking about their feelings is off limits but get them going in a group of their buddies and they will get the emotional support they need without ever mentioning a word about their feelings. I figured that if I could strengthen Robert's social network, he would achieve the same results I'd been trying to achieve with EFT—that of being able to soothe himself enough that he could better support Gladys. The problem was that Robert was unwilling to branch out and make new friends—at first because he was so busy perseverating on his insurance, and now simply because he was emotionally exhausted.

Consistent with the first and second principles, I realized I needed to switch to a more palatable approach to further achieve the goal I had been trying to achieve with EFT. I enjoy strategic therapy and figured that Robert, the stubborn, curmudgeonly engineer, might appreciate the concrete tasks and gamesmanship of it once he realized what was happening. Robert and Gladys loved their dogs. Gladys would regularly take them on a walk on the path behind their home in the morning, and Robert would take them in the afternoon. The path was busy, as was the dog park it intersected, but in the afternoon it was mostly busy with younger families; retired couples tended to use it in the morning. Robert knew this and did not want to socialize, which is why Gladys initially took the dogs in the morning. Over time, he forgot about the reason for Gladys's morning walks and their pattern simply became routine.

Robert was feeling better enough that I thought he would socialize if given the opportunity—he was just feeling afraid and antisocial and being stubborn as a result. One time I met for 10 minutes alone with Gladys and told her that I wanted her to run errands in the morning that week, so Robert would have to take the dogs on the morning walk. I hoped he would forget about the emotional risk of meeting new people, go on a walk, meet some friends, and start to open himself back up. Sure enough, for 2 weeks, Robert started interacting with the neighborhood retirees as he took his dogs on a morning walk. When they returned for their session, he started telling me about what his friend at the park was up to. Silently delighted, I tipped my hand by grinning a bit too much. He asked what was wrong with me, Gladys started laughing, and I told him about our plan.

"Hmmph!" he said as he folded his arms, furrowed his brow, and sat back in the couch. After a long pause, I said, "Oh, get over yourself, you grumpy old fart, and drag your bones over to the park! Seriously, enough gloominess already!" I was gambling that the alliance was strong enough that he would take my humor in stride and let it shock him out of his emotional rut. Startled, he sat up and tried to stay angry but could not repress a smile before breaking into laughter.

That marked a turning point for Robert, as it gave both Gladys and me more permission to get after him when he started to slide too far back into solitude. Within a few weeks, he was catching himself, and after a month, he was willingly engaged in the neighborhood social circle. As he did so, his mood gradually lifted, he stopped perseverating about the insurance, and started getting excited about plans for their future. As previously mentioned, Robert and Gladys had a strong marriage all along. My belief, informed by the third principle, is that if clients are given the right context, they will self-heal. In this case, I believed that if I could help them work through their trauma individually and learn how to support each other through this unique situation, their strong marriage had enough muscle memory that their healthy habits would naturally return, which they did.

Robert continues to see my colleague every 4–6 weeks for individual therapy. Another colleague sees Gladys, as she experienced a resurgence of trauma symptoms around the anniversary of the fire. I touch base with them occasionally when we cross paths in the office. Their marriage is strong. They are supportive of each other, enjoy spending time together, and join well together to solve their problems. Their social network is growing. They are able to comfort and soothe each other when the trauma becomes too much. They have gotten excited about remodeling a home they bought in Roseville. Their solution to grieving their old custom house while resigning themselves to living in generic suburbia was to tear down walls of their track home and incorporate design cues from their old house into their redesign. Recently, while eating lunch at a local café with my wife, I heard a lady say, just loud enough to be heard, "I can't believe they let riffraff like that eat here! Looks like we're gonna have to find a new place to eat!" I turned around to see Robert and Gladys looking at me and laughing hysterically. They are doing fine.

This case example is, of necessity, an oversimplification. Progress was not linear, mistakes were made, and I am sure that an EFT or strategic purist would rightly criticize my work. But keeping the common factors as a deliberate, consistent focus helped Robert and Gladys overlook my mistakes and stay engaged during the ups and downs. I believe my deep regard for them as fellow humans helped give them hope that they were in the right place. I adopted an I–Thou way of being by going out of my way to help them organize critical resources they were initially too overwhelmed to access themselves. I also treated them as humans by stepping back once their abilities increased, on the client-centered assumption that people will grow toward health given the right context. I monitored the alliance carefully throughout treatment by anticipating and trying to ameliorate dynamics that could lead to ruptures in the alliance. When a rupture occurred, I worked hard to repair it. I relied on the strength of the alliance to push them out of their comfort zones when necessary. I used my knowledge of certain aspects of their cultural demographics to interact with them in a way that strengthened the alliance and kept them engaged.

The alliance and an I–Thou way of being may have been necessary, but they were not sufficient, as Robert required specific interventions beyond the scope of couple therapy. This highlights the principle that even though skills and techniques alone are rarely the hero of therapy, sometimes they are uniquely useful. It depends on the case.

My initial efforts focused on the principles of instilling hope, a client-centered focus, and mobilizing external sources of healing by getting Robert and Gladys connected in the community. I stayed roughly consistent with my use of EFT until Robert's stalled progress indicated otherwise, at which point I applied the principle of seeing overlap among theories to realize that the goal I was pursuing with EFT was to get Robert to open himself up and let others support him. I used the principle of being passionate about theory rather than *a* theory to realize that I could reach the same end with strategic therapy, which was likely to be more palatable with Robert's personality. These are a few of the common factors used in treatment.

CONCLUDING COMMENTS

The truth is, I am sure far more things contributed to a successful outcome than I realize. And "successful outcome" is likely too simplistic. Life is long and relationships are complex, and to suggest that a round of any therapy will forever smooth out all of life's lows is naive. This is true of all therapy. We are a long way from a complete picture of what really comprises effective therapy, but to the extent the field remains humble about that naiveté, we learn more and more. Research on what makes an effective therapist, what pantheoretical processes are linked to outcome, how to match specific approaches with specific stages of treatment of specific presenting problems and with specific clients, and a greater understanding of principles of change are all examples of recent lines of inquiry inspired by common factors that promise to deepen our understanding of the change process.

SUGGESTIONS FOR FURTHER STUDY

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself?: The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33,* 298–317.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. D. (2014). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy, 40,* 22–33.

Halford, W. K., & Snyder, D. K. (2012). Universal processes and common factors in couple therapy and relationship education. *Behavior Therapy, 43,* 1–12.

Lebow, J. (2014). *Couple and family therapy: An integrative map of the territory.* Washington, DC: American Psychological Association.

Norcross, J. C., & Goldfried, M. R. (2019). *Handbook of psychotherapy integration* (3rd ed.). New York: Oxford University Press.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* New York: Guilford Press.

REFERENCES

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Benson, L. A., McGinn, M. M., & Christensen, A. (2012). Common principles of couple therapy. *Behavior Therapy, 43,* 25–35.

Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed., pp. 139–189). New York: Wiley.

Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analyses of data from the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64,* 1276–1284.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself?: The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33,* 298–317.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252–260.

Bradbury, T. N., & Bodenmann, G. (2020). Interventions for couples. *Annual Review of Clinical Psychology, 16,* 99–123.

Buber, M. (1958). *I and thou* (2nd ed., R. G. Smith, Trans.). New York: Charles Scribner's Sons.

D'Aniello, C., & Fife, S. T. (2020). A 20-year review of common factors research in marriage and family therapy: A mixed methods content analysis. *Journal of Marital and Family Therapy, 46,* 701–718.

Davis, S. D., Fife, S. T., Whiting, J. B., & Bradford, K. P. (2020). Way of being and the therapeutic pyramid: Expanding the application of a common factors meta-model. *Journal of Marital and Family Therapy, 47,* 1–16.

Davis, S. D., & Hsieh, A. (2019). What does it mean to be a common factors informed family therapist? *Family Process, 58,* 629–640.

Davis, S. D., Lebow, J., & Sprenkle, D. H. (2012). Common factors of change in couple therapy. *Behavior Therapy, 43,* 36–48.

Davis, S. D., & Piercy, F. P. (2007a). What clients of MFT model developers and their former students say about change: Part I. Model dependent common factors across three models. *Journal of Marital and Family Therapy, 33,* 318–343.

Davis, S. D., & Piercy, F. P. (2007b). What clients of MFT model developers and their former students say about change: Part II. Model independent common factors and an integrative framework. *Journal of Marital and Family Therapy, 33,* 344–363.

Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. D. (2014). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy, 40,* 22–33.

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy.* Baltimore: Johns Hopkins University Press.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Holyoak, D. L., Fife, S. T., & Hertlein, K. M. (2020). Clients' perceptions of marriage and family therapists' way-of-being: A phenomenological analysis. *Journal of Marital and Family Therapy, 47,* 85–103.

Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology, 61,* 678–685.

Hubble, M. A., Duncan, B. L., & Miller, S. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Johnson, S. M. (2019). *The practice of emotionally focused couple therapy: Creating connection* (3rd ed.). New York: Routledge.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy, 23,* 135–152.

Karasu, T. B. (1986). The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents. *American Journal of Psychiatry, 143,* 687–695.

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process, 43,* 425–442.

Knoblock-Fedders, L. M., Pinson, W. M., & Mann, B. J. (2007). Therapeutic alliance and treatment progress in couple psychotherapy. *Journal of Marital and Family Therapy, 33,* 245–257.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: Wiley.

Lebow, J. (2006). *Research for the psychotherapist: From science to practice.* New York: Routledge.

Lebow, J. (2014). *Couple and family therapy: An integrative map of the territory.* Washington, DC: American Psychological Association.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapy: Is it true that "Everyone has won and all must have prizes?" *Archives of General Psychiatry, 32,* 995–1008.

Mallinckrodt, B., & Nelson, M. L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology, 38,* 133–138.

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). Outcome-informed clinical work. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 84–102). London: Oxford University Press.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* London: Oxford University Press.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work: III. *Psychotherapy, 55,* 303–315.

Norcross, J. C., Lambert, M. J., & Wampold, B. E. (2019). *Psychotherapy relationships that work* (3rd ed.). London: Oxford University Press.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J. L., Rampage, C., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families.* Washington, DC: American Psychological Association.

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12,* 137–151.

Prochaska, J. O., & Norcross, J. C. (2009). *Systems of psychotherapy: A transtheoretical analysis* (7th ed.). New York: Brooks Cole.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21, 95–103.*

Rosenzweig, S. (1936). Some implicit common factors in diverse methods in psychotherapy. *Journal of Orthopsychiatry, 6,* 412–415.

Santisteban, D. A., & Szapocznik, J. (1994). Bridging theory, research and practice to more successfully engage substance abusing youth and their families into therapy. *Journal of Child and Adolescent Substance Abuse, 3,* 9–24.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy, 29,* 547–570.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins University Press.

Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couple therapy. *Clinical Psychology: Science and Practice, 6,* 348–365.

Sparks, J. A., Kisler, T. A., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy, 37,* 452–467.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30,* 113–130.

Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other non-technique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329–359). Washington, DC: American Psychological Association.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* New York: Guilford Press.

Stolk, Y., & Perlesz, A. J. (1990). Do better trainees make worse therapists?: A follow-up study of client families. *Family Process, 29,* 45–58.

Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91–132). Washington, DC: American Psychological Association.

Task Force Report on Promotion and Dissemination of Psychological Procedures. (1993). https://www.div12.org/sites/default/files/initialreportofthechamblesstaskforce.pdf.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work.* New York: Routledge.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: Norton.

CHAPTER 14

Integrative Systemic Therapy for Couples

Douglas C. Breunlin, William P. Russell,
Anthony L. Chambers, and Alexandra H. Solomon

BACKGROUND

Integrative systemic therapy (IST) is a psychotherapeutic perspective that provides a framework for transcending the specific models of therapy and accessing their concepts and interventions to meet the particular needs of specific cases. It is a comprehensive perspective in that it can be utilized in individual, couple, and family therapy, and applied to a wide range of client concerns. For these reasons, IST is not designed specifically and solely for couple therapy. Rather, it is used as a couple therapy either when a couple seeks treatment for that purpose or when the therapist deems that couple work is indicated when the original client(s) were either an individual or a family. IST is integrative, not eclectic, in that it has an underlying set of beliefs and principles—a foundational logic that maximizes the efficiency and effectiveness of the models and modalities it integrates (Lebow, 1997). IST is relentlessly multisystemic. When implemented as a form of couple therapy, IST is concerned with partners' coupleness, their individuality, their families, and their larger context.

The roots of IST grow out of the traditions of a systemic view of human problems and an integrative approach to handling them. IST's roots lie in a 40-year collaboration in Chicago among a group of theorists/clinicians/educators who were predominantly affiliated with The Family Institute at Northwestern University (formerly The Family Institute of Chicago) and the Institute for Juvenile Research. IST is rooted in the work of Douglas Breunlin and his colleagues who wrote the book *Metaframeworks: Transcending the Models of Family Therapy* (Breunlin, Schwartz, & Mac Kune-Karrer, 1997) and the work of William Pinsof, who wrote the book *Integrative Problem Centered Therapy* (1995). IST was also significantly influenced by the work of Jay Lebow on psychotherapy integration and common factors (Lebow, 1997, 2014). IST was developed at The Family Institute at Northwestern University where, for over 20 years, Pinsof, Breunlin, and William Russell taught the evolving perspective in graduate and postgraduate training programs in couple and family therapy. Prior to the perspective's designation as IST, it was called Integrative Problem-Centered Metaframeworks (Breunlin, Pinsof, Russell, & Lebow, 2011; Pinsof, Breunlin, Russell, & Lebow, 2011; Russell, Pinsof, Breunlin, & Lebow, 2016).

Anthony Chambers and Cheryl Rampage joined Pinsof, Breunlin, Russell, and Lebow to formulate a complete description of IST's theoretical framework and its clinical application, which can be found in Pinsof and colleagues (2018). IST has an extensive literature that articulates foundational concepts and descriptions of IST (see, e.g., Pinsof et al., 2018; Russell & Breunlin, 2019).

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

IST does not establish a dichotomy between healthy and distressed couple relationships. Rather, couples are viewed on a continuum from easy to very challenging from the perspective of the couple therapist. The variables that locate couples along this continuum are couple strengths, degree of complexity of their web of constraints, and the number of external stressors faced by the couple (which can also be framed as constraints).

IST is a strengths-based therapy. Its strengths guideline states: Until proven otherwise, it is assumed that the client system can use its strengths and resources to lift constraints and implement solution sequences with minimal and direct input from the therapist. At the outset of therapy, therefore, an assumption is made that the couple can be successful and that what prevents them from being successful are the constraints they face rather than the nature of any dysfunction.

A “constraint” is defined as anything in the couple’s biopsychosocial system that keeps the couple from resolving the concerns that brought them to therapy. The key to therapy is identifying and lifting those constraints. The more challenging the constraints are and the more difficulty the clients have in lifting the constraints, the more they will appear to be dysfunctional. The constraints can interlock with each other and form a web of constraints.

Sometimes constraints can be intractable, in which case the strain on the couple can intensify their distress. For example, one partner of the couple may have a chronic illness that impacts the functioning of the relationship. The illness can’t be eliminated, so the functioning of the couple will be impacted by the way they manage this intractable constraint. Couples face both internal and external stressors. Their capacity to remain stable depends, in part, on the strength of the stressors and their coping strategies for dealing with them.

THE PRACTICE OF IST COUPLE THERAPY

The Structure of the Therapy Process

Foundational Logic of IST

Every model of couple therapy has assumptions that underpin the logic of the model. Often, these are not stated explicitly and must be deduced. IST is explicit about its theoretical underpinnings and calls these underpinnings “pillars.” IST has five theoretical pillars that provide its conceptual foundation (Breunlin et al., 2011; Pinsof et al., 2018).

EPISTEMOLOGICAL PILLAR: PARTIAL AND PROGRESSIVE KNOWING

This pillar asserts that there is an objective reality, but humans are limited in their ability to know it. Our knowledge is always partial. We are limited by our perspectives. Knowledge is also progressive: A therapist knows more about a couple after 3 months than after one meeting and will know more after a year. We can get closer to knowing the reality of their relationship but can never know it completely or definitively.

The key implication of partial and progressive knowing is that assessment is a never-ending process. In IST, assessment and intervention are inseparable over the course of therapy. An IST therapist continually formulates hypotheses about a couple’s problems and the constraints that prevent their resolution. These hypotheses constitute an evolving assessment that can become increasingly refined, accurate, and sufficient to facilitate resolution of the couple’s problems.

ONTOLOGICAL PILLAR: SYSTEMS THEORY

This pillar posits that the nature of being is that of multilevel systems. A couple is a system comprised of individual subsystems that exist within a larger set of family and kinship systems that, in turn, are housed in community and societal systems. As a system, the couple is more than the sum of its individuals. It has attributes pertaining to its coupleness that cannot be explained by the characteristics or personalities of the partners.

The couple cannot be understood independently of the individuals within it and the systems in which it is embedded. The therapist needs to empathically understand each partner and the issues they bring to their relationship—for better and for worse. Each partner is a system whose biopsychosocial homeostasis impacts the problems for which the couple is seeking help. The therapist must also consider the impact of the family systems that contextualize the couple, including their families of origin and their own children.

CONSTRAINT PILLAR: THEORY OF CONSTRAINTS

Based on Bateson’s (1972) theory of negative explanation, IST views couple problems as the products of sets of constraints within the couple system that prevent the couple from resolving their problems (Breunlin, 1999). IST assumes partners possess the capacity to resolve their problem but are constrained from doing so. Constraints interconnect and constitute a web. As with a spider's web, a change in or elimination of one constraint affects the whole web, changing its architecture and the pathways that connect the constraints.

CAUSALITY PILLAR: MULTIPLE, MUTUAL, AND DIFFERENTIAL CAUSALITY

IST recognizes the complex patterns of mutual influence that exist between partners and among other levels of systems. The multiple constraints comprising a couple's web interact with each other and contribute to the problem. All constraints, however, do not contribute equally to preventing a problem's resolution. Causality is differential as well as mutual. In one couple, the affect regulation problems associated with an underlying bipolar disorder play a key role in stimulating and maintaining conflict, whereas the work stress of that partner is a factor but is significantly less constraining. The diagnostic challenge is to discern the relative contribution of the different constraints to the problem's variance.

SEQUENTIAL ORGANIZATION PILLAR

A clinically useful way to understand and address couple problems is the sequential organization—in space and time—of their interactions (Breunlin, Schwartz, & Mac Kune-Karrer, 1992, 1997). Problems manifest themselves within problem sequences, which are the recurrent patterns of interaction that contain the problem. Sequences can be characterized according to their periodicity, with some unfolding in seconds or minutes, others transacting over the course of a day or week, others that lay out over weeks or months, and still others that repeat across generations. Sequences can involve feelings, thoughts, and behaviors, and can be intrapersonal and/or interpersonal. A typical couple problem sequence might involve emerging closeness, anxiety about disappointment or emotional injury, provocation of conflict, and emotional withdrawal/disengagement. Constraints prevent the couple from implementing what IST calls "solution sequences." Problem sequences sustain the couple's systemic homeostasis. The transformation of that maladaptive homeostasis requires the implementation of solution sequences.

The pillars support a collaborative problem-solving approach that tailors a systemic therapy to the needs and patterns of the couple presenting for therapy. The work is based on partners' goals, therapist knowledge stored in metaframeworks that facilitate conceptualizing and intervening, and a set of guidelines for the conduct of therapy that we discuss later in this chapter.

The Problem Focus and the Direct Client System

IST is a problem-solving approach. It strongly encourages the recognition of strengths and solutions, but it begins with the careful definition of the presenting problem. This provides a focus for therapy and meets the couple where they are. It is the first step in demonstrating that the therapist is there to address the couple's needs. It is the beginning of a collaboration and an alliance. Additional problems may be identified over the course of therapy, but they become a focus of therapy only if the couple is on board with that. The exception to this rule would be patterns of behavior that are dangerous or damaging.

The couple is defined as the direct client system. Family members or other significant people in the system are defined as the indirect client system. This distinction is important, as it promotes awareness that intervention with the direct client system influences and is influenced by members of the indirect client system. Furthermore, this distinction carries the idea that the decision about who attends the therapy may change, such that members of the indirect system may at a point in time move into the direct system.

Consistent with its systemic underpinnings and its interpersonal guideline suggesting that, unless contraindicated, it is better to intervene with an interpersonal system, IST therapists include both partners in the direct client system. In other words, they will convene the couple conjointly for therapy. Specific circumstances or constraints may lead the therapist to schedule an individual session for each partner, but by and large the sessions include both partners. When indicated, an adult child or a partner's parents may be invited for a focused session, if they are involved in a specific constraint to progress. In IST, the question of who attends the sessions is determined by hypotheses about who can help solve or improve the concerns presented by the couple. Sessions are typically conducted once per week, though they may be more frequent when intensive work is required. As therapy progresses, sessions may be scheduled less frequently, especially as the work moves into the phase of maintaining progress.

The IST Essence Diagram

IST's systemic and integrative nature, its problem-solving orientation, its focus on problem and solution sequences, and its constraint pillar inform the structure of therapy. A generalized structure for therapy containing these elements is seen in the problem-solving steps of the IST essence. First, IST convenes the couple and focuses directly on the concerns they present for therapy. The therapist works carefully to develop a consensus on why the couple has come to therapy. When a consensus is not possible, the therapist works to develop an umbrella problem statement that contains interlocking aspects of each party's concerns. Second, while understanding that there are many factors that influence a couple's relationship, the therapist seeks an initial, simple systemic description of how the problem lays out that is called the "problem sequence." Third, the therapist and couple collaborate to identify and implement an alternative and more adaptive sequence called the "solution sequence," which, when enacted, either leads to progress or invites the therapist and couple to discover more about the system. Fourth, when the couple does not enact and maintain a solution sequence, the therapist guides them to search for the systemic factors that constrain their efforts. Fifth, to address these specific constraints, IST utilizes relevant interventions that are drawn from a variety of models and from the research on couples and couple therapy. In this way, IST couple therapy is tailored to the couple and not determined by a model. Sixth, IST seeks to establish and maintain solution sequences, those new patterns that improve or solve the presenting concerns of the couple.

This work is focused on what the couple wants to accomplish and not on an idealized conception of what a couple should be. As the work develops, new problems may be identified. For example, as a couple solves the conflict that brought them to therapy, they may express interest in rekindling their sexual relationship. This would constitute a new goal and iteration of the therapy.

The structure of the therapy is represented in a flowchart, the essence of IST, which is depicted in Figure 14.1 (Russell et al., 2016). The flowchart demonstrates the generalized problem-solving tasks of IST and provides therapists with guidance on what they need to do both in a given session and across sessions.

As each problem-solving step is addressed, the therapist has the responsibility of promoting collaboration and is careful to ascertain that the couple is on board with the views and actions proposed in the therapy. At each step in the process, the therapist is aware that intersectionality

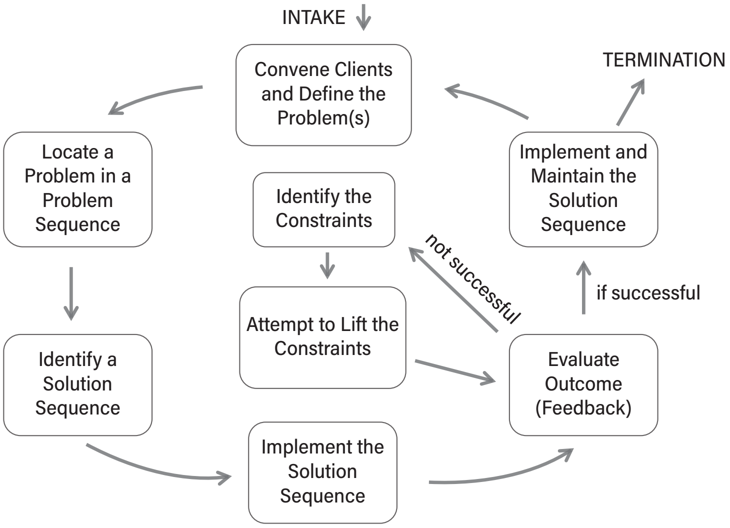

INTAKE
Convene Clients and Define the Problem(s)
TERMINATION
Locate a Problem in a Problem Sequence
Identify the Constraints
Implement and Maintain the Solution Sequence
not successful
if successful
Attempt to Lift the Constraints
Identify a Solution Sequence
Evaluate Outcome (Feedback)
Implement the Solution Sequence

FIGURE 14.1. Problem-solving essence of IST. From Russell, Pinsof, Breunlin, and Lebow (2015). Copyright © 2016 Routledge. Reprinted by permission.

of cultural contexts and social justice issues may influence whether the language spoken and the actions taken are respectful and fitting for the couple. Soliciting and attending to the couple's feedback promotes the therapeutic alliance that, according to IST's alliance predominance guideline, is privileged over the therapist's hypotheses and plans. The process by which the essence steps are accomplished, and the knowledge and strategies required to accomplish them, are provided by the IST blueprint.

The Blueprint for Therapy

In IST, the problem-solving steps of the essence diagram, as well as the relational aspect of maintaining a therapeutic alliance, are accomplished using a decision-making and decision-evaluating process called the *IST blueprint*. The blueprint serves as a generic clinical guide that replaces the specific clinical logic of each model, thus rendering integration of them possible. The blueprint, depicted in Figure 14.2 (Breunlin et al., 2011), has four components: conversing, reading feedback, hypothesizing, and planning.

The conversing dimension of the blueprint defines therapy as an idiosyncratic and improvisational conversation, led and facilitated by the therapist from an integrative perspective. Conversing includes the collaborative process of presenting hypotheses and interventions to the couple in the hope of establishing and strengthening the alliance and resolving the presenting concerns of the clients. Reading feedback entails evaluating the reactions of clients to the conversation and interventions. Conversing and reading feedback constitute the therapy process.

Hypothesizing and planning occur primarily in the therapist's head. Hypothesizing incorporates the conceptual contributions of the models, as well as ideas drawn from relevant fields of knowledge in the service of understanding the clients and what is needed to resolve their presenting problems. Planning is the process of collaboratively deriving interventions to resolve the presenting problem or lift the constraints that are preventing their implementation.

The blueprint is used at the micro level of practice by facilitating moment-to-moment decision making. It is also used at a macro level of practice to plan and execute larger scale interventions such as working through the stages of divorce. The blueprint repeats itself on micro and macro levels throughout therapy. If feedback indicates that the essence step is not accomplished or the interventions did not work, the conversation returns to hypothesizing, integrating the feedback into new hypotheses. This generates a new cycle of conversing, reading feedback, and planning. We discuss the blueprint in greater detail in a subsequent section that addresses the process and technical aspects of couple therapy.

The Role of the Therapist

The role of the IST couple therapist is to establish a collaborative relationship with couples and facilitate relational change in support of their goals for therapy. This is a problem-solving endeavor that may target conflict, connection, intimacy, loss, or individual adult problems such as physical or mental illness. A couple's autonomy and their leadership of their own lives are deeply respected in IST. Clients are responsible for their lives. The therapist is responsible for leading the therapy process but is careful to respect the couple's goals and preferences in order to maintain a strong therapeutic alliance. The therapist models the importance of interpersonal alignment on goals and tasks of therapy.

The IST therapist does not establish targets for the couple based on normative or ideal conceptions for how couples should be in a relationship. The therapist does bring knowledge about relationships and interventions, but it is in the service of what the couple seeks to accomplish. The therapist will notice a variety of constraints, but the constraints that become the subject of therapy are

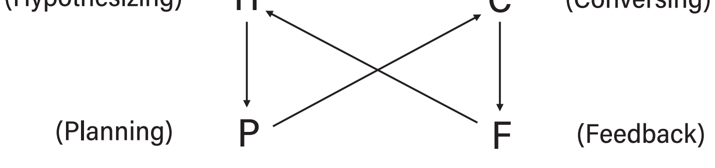


FIGURE 14.2. IST blueprint for therapy. From Breunlin, Pinsof, Russell, and Lebow (2011). Copyright © 2011 John Wiley & Sons, Inc. Reprinted by permission.

those that prevent the couple from accomplishing what they want to accomplish. With respect to these constraints, the therapist takes the role of co-investigator as therapist and couple work to uncover, manage, and/or remove constraints. The therapist also takes the role of educator in sharing knowledge and expertise, teaching skills, and recommending interventions. Last, and this is indirectly but impactfully experienced by the couple, the therapist has the role and responsibility to cultivate the person-of-the-therapist (Aponte & Kissil, 2016), who is committed to self-discovery as it relates to the therapeutic process. This work helps therapists see how their own patterns of thinking, feeling, and acting can constrain therapy, and helps them bring more of themselves to the process of therapy.

Assessment and Treatment Planning

Assessment, planning, and intervention are all part of an ongoing, iterative process of hypothesizing and testing hypotheses that occurs over the entire course of therapy. In this sense, the treatment planning is not completed on the basis of an initial assessment. It is planned within the conduct of the therapy as the blueprint continually reveals new information. The purpose for hypothesizing and testing hypotheses is the accomplishment of the tasks in the essence diagram. Thus, the ongoing assessment that IST calls "hypothesizing" begins with the identification of the problem and problem sequences, and proceeds through the steps of the essence.

In the first session, the therapist identifies what the couple wants to accomplish and learns about their context and background. IST does not require that the therapist do a formal assessment or gather extensive information at the outset of therapy. IST practitioners rely on the process of therapy going forward to produce the information they will eventually need. Although a formal assessment is not required in IST, there are two factors that may lead to a variation in which therapy begins with one. First, some agencies or practices may require a more extensive or formal assessment. Second, therapy with a couple can be challenging and, at times, overwhelming. Thus, some therapists prefer to utilize an extended initial evaluation (e.g., the one described below) to manage this challenge (see also Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin). This can be helpful with complex cases, and it may be preferred by therapists in training and those who enjoy getting more of the lay of the land before jumping into the problem-solving process.

The Four-Session-Evaluation Option

As noted, IST views assessment and intervention as a recursive and continuous process that occurs throughout therapy. The therapist is continually assessing and planning the therapy as solution sequences and constraints are identified. Assessment unfolds recursively as the attempts to solve the problem reveal more information about the system and help define the constraints that will need to be addressed. Over the course of therapy, the therapist seeks to understand the individuals, their relationship, the environmental contexts in which the individuals and the relationship operate, and the multidirectional influences of each of these levels of the system. Given an agency requirement, a training regimen, or a therapist preference, IST can accommodate a more formal initial assessment such as the four-session evaluation (Chambers, 2012). Although the four-session evaluation option seeks a wider initial view of the couple and their contexts, it does not alter IST's commitment to ongoing assessment through intervention which continues until the couple completes therapy.

The four-session couple evaluation includes an initial conjoint session to explore the couple's relationship problems followed by separate sessions focused on each person's individual and family of origin histories (Chambers, 2012). The evaluation concludes with the therapist providing feedback to the couple, which is used to define an initial direction for therapy and establish a working alliance.

The four-session evaluation is compatible with the IST framework in several important ways. First, it is systemic in nature. Complexity is a central concept in systemic epistemology (Stanton, 2009). The four-session model embraces the systemic complexity of couples' problems by delineating a procedure to begin to navigate the complexity. Second, the four-session model is transtheoretical. This is important, as Stanton and Welsh (2011) note that conducting an evaluation within a particular theoretical orientation may overlook important factors. Thus, the four-session model has the potential to accommodate a range of systemic theoretical orientations. Third, the four-session evaluation incorporates a client-centered, problem-driven approach. Finally, the four-session evaluation is viewed as a brief intervention and thus intentionally blurs the lines between assessment and intervention.

Throughout the evaluation, the therapist asks questions to identify the constraints facing the couple. The goals of the conjoint session are to build balanced alliances, garner basic information about the couple's life, ask questions aimed at uncovering constraints, and explore the presenting problem sequence in detail. The goals of the individual sessions are to strengthen individual alliances with each partner, assess each partner's feelings about their own and their partner's level of commitment to the relationship, and garner individual and family-of-origin histories, as well as a history of previous romantic relationships. In the feedback session, the therapist describes an integrated conceptualization of the problem sequence, tests out hypotheses, delineates constraints, and recommends an initial solution sequence. The four-session evaluation has many nuances; a more detailed description of it as well as a full case example are provided by Chambers (2012).

Goal Setting

In IST, goal setting is a reiterative process represented in the essence diagram. A goal is agreed upon by the therapist and couple in the sense that they reach an agreement on a presenting problem(s) and decide to seek solutions to it (them). Thus, a couple and therapist might agree on a goal of reducing conflict. The conflict the couple experiences is then explored from the standpoint of their actual patterns of interaction, including the meanings and emotions they experience. What will be done to achieve a goal unfolds as the therapist encourages the couple to experiment with solutions, helps them identify constraints to those solutions, and recommends strategies and interventions to remove the constraints.

Process and Technical Aspects of Couple Therapy

Couple therapy in IST requires therapists to be skilled in using knowledge stored in the blueprint to address the couple's concerns within the structure of the essence steps. It is essential for therapists to build a knowledge and skills base for each of the blueprint components (conversing, feedback, hypothesizing, and planning) and to learn to access that knowledge and skill in service of addressing IST's problem-solving tasks (see the essence diagram in Figure 14.1). Each step of the blueprint is summarized below.

Conversing

"Conversing" refers to the in-session conversation between the therapist and clients. Conversing emerges from planning as the therapist decides to address an essence task (e.g., lifting a constraint) or an alliance issue. For example, given the hypothesis that one partner seems reactive to something the therapist has said, the therapist plans what to say to the couple, then implements that in conversation with the couple. Larger arc planning influences conversing as well. For example, the therapist plans to introduce a time-out procedure, then, in conversing, explains the procedure in detail and asks for the couple's feedback about it. Conversing is the vehicle for intervention in which a new view is offered, an important feeling is explored, or a new action is encouraged. Although planned, actual therapeutic conversation is an art that is invariably idiosyncratic and improvisational. The therapist leads and facilitates a respectful and purposeful conversation to help the couple create new, more adaptive sequences of interaction.

Although conversing involves a co-created conversation, the therapist's role differs in important ways from the partners' roles. The IST couple therapist creates a safe environment in which both partners can express their thoughts and feelings without being attacked, shamed, or abused. At times, the therapist must use their authority to stop destructive conflict or abuse sequences in therapy. This is not intended to discourage or restrict the expression of intense and painful emotions, but rather to prevent destructive interactions. Without being heavy-handed, the therapist needs to communicate that they will do what it takes to prevent aggression or unnecessary pain.

In the process of conversation, the IST couple therapist suggests and encourages alternative adaptive behaviors. If the partners cannot engage in these solution sequences, this "failure" is welcomed as an opportunity to learn more about the partners and their web of constraints. In most situations, the therapist is not invested in being right or having the answers. The attitude is "Let's try this and see how it works." Being wrong and making mistakes are welcomed as opportunities to be human, humble, and capable of learning from failure.

Feedback

"Feedback" represents the ongoing information in the therapy system (therapist and couple). Sources of feedback include statements by the partners, nonverbal expressions, therapist observations of couple interaction, change in patterns over time, data from progress instruments, and therapists' own emotional reactions. Feedback, along with the therapist's ability to interpret it, is the basis of hypothesizing. Feedback will support hypotheses about the alliance, problem sequences, solution sequences, constraints, the outcome of an intervention, and the progress of therapy. Feedback is what therapists need to know in order to know what they are doing.

Feedback from the couple lets the therapist know if they are on board with experiments with solution sequences. The therapist also carefully reads the feedback that results from the couple's attempts to implement the experiments—including information about the process and outcome of the experiments, as well as the partners' thoughts and feelings about them. The entire process of moving through the essence diagram tasks is a function of feedback. Every next step results from or is shaped by the incorporation of feedback. Reading the feedback requires that the therapist pay very close attention to what is happening in the session. This is a formidable task when there are two partners in the room. Although all feedback is potentially valuable, the therapist can limit the field of data interpreted by focusing primarily on feedback about the alliance and feedback on the hypothesis or plan that has been developed.

Couple therapy can be empirically informed by the use of a systematic feedback instrument. Pinsof, Tilden, and Goldsmith (2016) compared and reviewed the extant measurement and feedback systems that were developed over a 20-year period. Such instruments provide the therapist with data on the progress of therapy, the experience of the client, and the therapeutic alliance. In IST, this feedback is included with other, more experiential feedback to help the therapist form or refine hypotheses and related plans.

Hypothesizing

Within the blueprint, the therapist guides a set of conversations that generate feedback and uses this feedback to hypothesize about the nature of the problem sequence, then about the solution sequence, and finally about constraints and how to lift them. Hypothesizing about the couple and their problems occurs within certain parameters that constitute a two-dimensional web of human experience depicted in Figure 14.3 (Breunlin, Pinsof, & Russell, 2018). The first (circular) dimension delineates the six system levels of the biopsychosocial system, with the outer rings encompassing the inner rings. In couple therapy, the couple ring is primary, with constraints from inner (person) or outer (family, etc.) circles relevant insofar as they affect the couple. The second (linear) dimension specifies seven hypothesizing metaframeworks that address different domains of knowledge about the formation and maintenance of couples' problems. The metaframeworks—organization, gender, development, mind, culture, biology, and spirituality—represent seven axes that cut across the system levels. The web of human experience is a heuristic device or metaphorical structure to facilitate the generation and testing of hypotheses about the couple, including those concerning the therapeutic alliance, couple strengths, solution sequences, and constraints.

The Hypothesizing Metaframeworks

Hypothesizing metaframeworks transcend the specific theories of problem formation and maintenance that underlie many models of couple therapy. Organizing a domain of human functioning, each metaframework is an evolving body of knowledge that can incorporate new theories and research findings as they emerge. Each hypothesizing metaframework can be applied isomorphically to each system level (circle) in the web of human experience.

ORGANIZATION

Organization addresses how the partners fit together and function as a whole. It addresses social roles and the way the couple fits within other systems such as family and community. The two central organization constructs are boundaries and leadership. A "couple boundary" differentiates the couple from the rest of the client system. This includes a generational boundary between the partners and their children, as well as between the partners and their families of origin. A boundary also distinguishes the couple from friends and community. Couples have styles of leadership that govern their decisions about who can do what and how resources are allocated. Couple leadership patterns need to change as the needs of the couple and the demands of the environment change. The operative question for the therapist and couple is whether boundary or leadership patterns seem to constrain the couple from implementing solutions sequences.

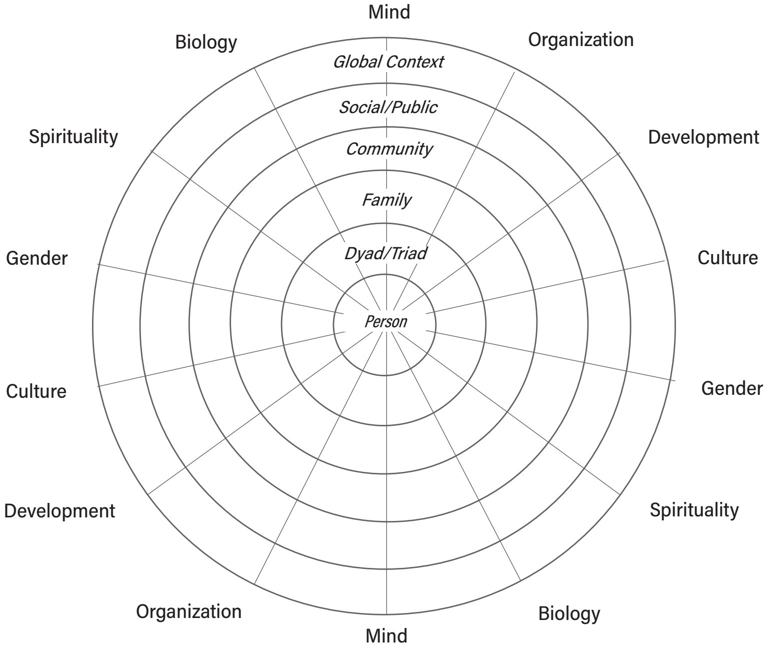


FIGURE 14.3. IST web of human experience. From Breunlin, Pinsof, Russell, and Lebow (2011). Copyright © 2011 John Wiley & Sons, Inc. Reprinted by permission.

GENDER

This metaframework stores information and theory pertaining to gender identity, gender roles, and gender equity. Feminist considerations (Rampage, 2002) and male development issues (Real, 1997, 2002) provide templates for understanding the creation and maintenance of couples' problems. Transgender and gender-fluid individuals live in a larger context of cisgenderism. In addition to the challenges that all couples face, they deal with familial, community, and societal factors that assault or deny their gender identities (see also Chapter 23 on queer couples, in this volume, by Coolhart). These external constraints are experienced and processed by each partner according to their own views and coping mechanisms.

DEVELOPMENT

Couples must maintain a stable and satisfying relationship throughout four overlapping system life cycles: individual, couple, nuclear family, and families of origin. Occasionally, developmental issues associated with these life cycles work synergistically; however, it is likely that developmental dyssynchrony within or between these different life cycles will constrain the couple's capacity to implement solution sequences. Identifying developmental constraints can help therapists see where the couple or partners are "stuck," as well as the developmental work that needs to occur. Labeling and contextualizing the couple's issues in developmental terms creates empathic understanding and illuminates opportunities to modify the dyssynchrony or facilitate developmental transitions.

MIND

Mind addresses hypotheses about a couple's thoughts, emotions, and intentionality. The simplest and initially preferred level of analysis of mind simply describes the partners' sequences of emotions, thoughts, or narratives that can be sources of strength or constraint in the process of problem solving. When a straightforward analysis of thoughts and emotions does not lead to an effective plan for intervention, the therapist can draw on various theoretical models — for example, object relations theory (see Chapter 7, in this volume, by Siegel) or a theory of self (Kohut, 1984) to link current feelings and thoughts to internal representations of early attachment figures or traumatic experiences.

CULTURE

Each partner in a couple draws their identity in part from simultaneous membership in multiple contexts that include ethnicity, race, religion, class, geographic region, economic status, education, sexual orientation, and age. The culture metaframework addresses strengths and constraints regarding these "contexts of membership" (intersectionality). (See also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim.) The therapist will need to be considerate of the identities, beliefs, and practices of the couple. This is particularly important when it comes to prescribing solution sequences, identifying constraints, and suggesting actions to modify constraints. IST therapists incorporate a multicultural perspective, intersectionality, and social justice into practice. This requires that therapists develop an understanding of the constraining influence of their own cultural contexts and an openness to understanding the implications of the cultural contexts of couples. Included in this effort is an ongoing commitment to learning about nondominant cultural contexts and the impact and effects of oppression.

BIOLOGY

Advances in neurobiology and its potential to better understand the "mind–body" connection (Siegel, 2007) and interpersonal relationships (Fishbane, 2007, 2013; Siegel, 2012) support the elaboration of a metaframework to address biological constraints. This metaframework also addresses the impacts of injury and illness, including mental illness, on a couple. Aging, sexual health, and the fast-evolving field of genetics are other examples of factors within the biology hypothesizing metaframework that can challenge couples.

SPIRITUALITY

Spirituality involves partners' "relationship with God, or whatever is held to be that which fosters a sense of meaning, purpose and mission in life" (Hodge, 2001, p. 204). Spirituality involves "transcendent beliefs and practices," within or outside formal religion (Walsh, 2010, p. 331). Spiritual processes such as faith, hope, prayer, transcendence, letting go, and acceptance can be sources of strength and resilience for couples. Spirituality can also be constraining, for example, when couples have difficulty managing spiritual differences or when a partner "hides out" in their spirituality, avoiding responsible action or vulnerable emotions such as fear or sadness.

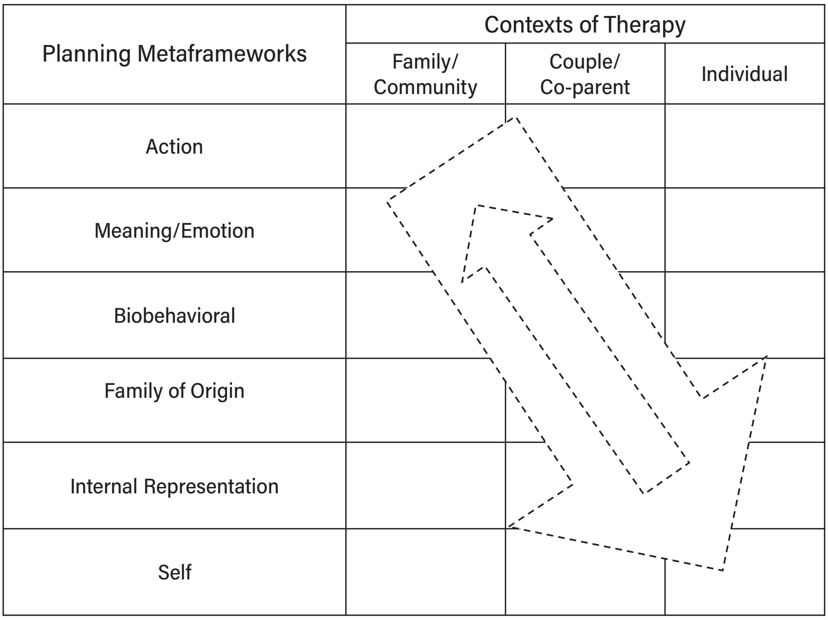
Planning

The planning process for addressing constraints is informed by the two-dimensional matrix presented in Figure 14.4 (Pinsof et al., 2011). The first dimension targets three primary direct client system contexts in which interventions can be deployed—family, couple, and individual. This dimension constitutes the vertical columns. These columns are intersected by six rows representing the six planning metaframeworks, each of which organizes strategies for change according to its respective mechanisms of change. The IST guidelines, represented by the arrows, provide a preferred order of application of the planning metaframework strategies.

The Planning Metaframeworks

Each planning metaframework has two components. The first is a set of strategies that addresses the targets of clinical practice. They specify what the therapist wants to accomplish. For example, with a couple dealing with an affair, one strategy would be to promote forgiveness. With a high-conflict couple, an initial strategy would be to deescalate the conflict. The second component of a planning metaframework is the set of interventions used to accomplish the strategies. Each strategy can be accomplished using a number of different interventions. IST therapists build a repertoire of interventions, the most complex of which require training that is most readily available within the tradition of the model from which it was derived.

The first three planning metaframeworks—action, meaning/emotion, and biobehavioral—are the here-and-now metaframeworks. Their temporal orientation focuses on current or recent relationships and activities, and related behaviors, thoughts, and feelings. The last three planning metaframeworks—family-of-origin, internal representation, and self—focus on past relationships in families of origin and the internalized processes of mind that resulted from that experience. From a problem-centered perspective, historical experience becomes relevant insofar as it functions as a remote constraint that prevents current implementation of a solution sequence. IST works first



Planning Metaframeworks	Contexts of Therapy		
	Family/ Community	Couple/ Co-parent	Individual
Action			
Meaning/Emotion			
Biobehavioral			
Family of Origin			
Internal Representation			
Self			

FIGURE 14.4. IST planning matrix. From Pinsof, Breunlin, Russell, and Lebow (2011). Copyright © 2011 John Wiley & Sons, Inc. Reprinted by permission.

with strategies drawn from the here-and-now planning metaframeworks and moves, if necessary, to strategies located in the historical planning metaframeworks.

Importantly, IST does not classify models of therapy within the planning metaframeworks. Neither does it specify a progression for working with one model or another. Rather, it abstracts strategies from models and other sources (common factors research, research on specific problems) and organizes those strategies in planning metaframeworks according to mechanisms of change. The vast majority of interventions utilized to fulfill a strategy were developed within specific models of therapy. A model may contribute interventions to more than one planning metaframework. IST recognizes the extraordinary contributions of the models and acknowledges that utilizing an intervention requires an understanding of it, as well as proficiency with it. Some interventions can be relatively simple to deliver; hence, therapists can begin to work with them and learn to be more skillful with them over time. In other cases, especially when a larger module of work is adopted, significant training in the intervention is required. In all cases, an intervention is chosen to address a specific sequence of interaction or hypothesized constraint that interferes with an adaptive solution to the couple's concerns.

THE ACTION PLANNING METAFRAMEWORK

The action metaframework contains strategies and associated interventions that provide couples with the opportunity to modify their patterns of action and interaction. An action plan requires a collaborative understanding between therapist and clients that is established in the realm of cognition and/or emotion, but the central focus of an action strategy is to initiate change through action. Action strategies are accomplished by interventions drawn from many sources, including cognitive-behavioral (see Chapter 3, in this volume, by Baucom et al.), Gottman method (see Chapter 16, in this volume, by Gottman & Gottman) and structural (Fishman, 2012) approaches.

THE MEANING/EMOTION PLANNING METAFRAMEWORK

The meaning/emotion metaframework contains strategies and associated interventions that focus on modifying patterns of thoughts and feelings. These strategies seek to access adaptive emotions, regulate constraining emotions, or develop adaptive cognitions, meanings, or narratives. The meaning/emotion strategies include interventions that may be drawn from many approaches detailed in other chapters in Part II of this *Handbook*.

THE BIOBEHAVIORAL PLANNING METAFRAMEWORK

The biobehavioral metaframework contains strategies and interventions that are targeted to modify underlying biological processes that constrain a solution sequence. Biobehavioral interventions include medication, biofeedback, neuroeducation and attunement (Fishbane, 2013), progressive muscle relaxation (McCallie, Blum & Hood, 2006), sensate focus (Nelson & Hunt, 2016), mindfulness, meditation, and physical exercise.

THE FAMILY-OF-ORIGIN PLANNING METAFRAMEWORK

The family-of-origin metaframework contains strategies that support intervention in partners' relationships with their families of origin, with the goals of increased differentiation of self and mature interdependence. The family-of-origin metaframework draws on strategies and specific interventions from the work of family therapy pioneers (Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Framo, 1992), as well as more recent intergenerational approaches (McGoldrick, Gerson, & Petry, 2008; see Chapter 9, in this volume, by Fishbane).

THE INTERNAL REPRESENTATION PLANNING METAFRAMEWORK

The internal representation metaframework contains strategies that address internalized mental representations based primarily in early relational experiences. These strategies seek to modify internal objects or parts of mind, the relationships among them, and/or the relationship between the objects/parts and other people. The internal representation strategies utilize interventions such as those derived from object relations theory (see Chapter 7, in this volume, by Siegel) and internal family systems (IFS) therapy (Schwartz, 1995).

SELF PLANNING METAFRAMEWORK

The self metaframework targets intervention in the therapist–client relationship as the means of helping a partner develop a stronger, more flexible self. When the therapist has worked extensively with the other planning metaframeworks but constraints of mind persist, work at this level is recommended. Self psychology (Kohut, 1977) provides concepts to support the analysis of transference and repairs to ruptures of the therapeutic alliance. If a client is self-harming, highly reactive to criticism or rejection, or satisfies the diagnostic description of borderline personality, dialectical behavior therapy (Fruzzetti & Payne, 2015) is an efficacious first option for treatment.

Utilizing Planning Metaframeworks: What, When, and with Whom?

In addition to the planning metaframeworks, IST espouses a set of guidelines that specify how the strategies and interventions from the planning metaframeworks should be utilized. Before articulating these guidelines, it is important to clarify the relationship between the contexts and metaframeworks in Figure 14.4. In this matrix, the metaframeworks cut across the contexts: The strategies and interventions in each metaframework can be utilized in family, couple, and/or individual contexts. In IST couple therapy, this means that strategies from all of the planning metaframeworks can be utilized in the couple context.

The IST Principle of Application

The matrix in Figure 14.4 contains a large arrow that runs from the upper left-hand corner toward the lower right-hand corner. This arrow shows that the order of presentation of the planning metaframeworks (higher to lower) is intentional and prescriptive. The arrow metaphorically reflects the IST principle of application, which asserts that therapy should generally progress from the upper left-hand corner of the matrix toward the lower right-hand corner. This means that, unless contraindicated by matters of safety or alliance issues, the therapy should begin with both partners in the direct client system and focus initially on addressing constraints with the three here-and-now planning metaframeworks—action, meaning/emotion, and biobehavioral. If these strategies and techniques do not facilitate implementation of the solution sequences, the therapeutic focus shifts, still in a couple context, to strategies and techniques from the historically oriented planning metaframeworks. If that work is not successful, the therapist might determine that one or both partners require additional support that can be provided within the context of individual sessions. These sessions can sometimes be given by the couple therapist. Referral of a partner to another therapist for individual therapy is indicated when the need for and extent of individual support is so great that it would unbalance the alliances for it to be provided by the couple therapist. If a referral is made to another therapist for individual therapy, the couple therapist must decide whether the conjoint work can proceed in parallel to the individual therapy. In addition, if both therapies occur concurrently, it is highly recommended that permissions be obtained for the two therapists to be in contact with each other.

The smaller arrow, going back up the matrix, reflects the problem-centered focus: As the therapy draws strategies from lower on the matrix, it never loses touch with the work that still needs to be done at the higher levels to implement the solution sequence(s). The IST principle of application, depicted by the large arrow in the matrix, is driven by the following intervention guidelines.

THE FAILURE-DRIVEN GUIDELINE

The progression in the principle of application reflected by the arrow is not an ideal or "best-case" progression (as going "deeper" is with a classic psychodynamic framework), but rather a "failure-driven" progression; that is, movement down the matrix is driven by the failure of the upper-matrix work to modify the constraints sufficiently to allow consistent enactment of solution sequences.

THE INTERPERSONAL GUIDELINE

A core IST guideline is that it is preferable to use strategies and interventions in an interpersonal as opposed to an individual context when possible and appropriate. This applies even to family-of-origin and internal representation planning metaframeworks, with the rationale that the impact on the couple in terms of mutual understanding will be greater if the work can be done conjointly. Although IST privileges interpersonal-context work, individual-context sessions can be used judiciously and effectively within IST couple therapy, especially as the therapist becomes aware that a partner is having difficulty establishing or maintaining an adequate alliance with the therapist. Whenever IST therapists meet with a partner individually, they must remind both partners about the policy on secrets (typically a "no secrets" policy) and be sensitive to possible issues related to trust (Chambers & Lebow, 2008). Ongoing individual therapy with another therapist is recommended when it is deemed that this is the only context capable of lifting powerful individual constraints.

THE COST-EFFECTIVENESS GUIDELINE

The cost-effectiveness intervention guideline asserts that it is better to use the most direct and least expensive interventions with a couple before using more indirect and expensive interventions. Strategies associated with the first three planning metaframeworks assume that the couple will be able to achieve their goals with direct and relatively straightforward interventions. If this proves not to be the case, therapy shifts down the matrix and begins addressing more historical constraints that will require a lengthier and, consequently, more costly therapy.

THE TEMPORAL GUIDELINE

The arrow within the organization of the matrix privileges intervention strategies and techniques that address current constraints. Simply stated, therapists should focus on current or proximal constraints before addressing more remote or distal ones.

THE ALLIANCE PREDOMINANCE GUIDELINE

The most critical and necessary (but not sufficient) aspect of the therapeutic process is the development and maintenance of a good therapeutic alliance with the couple. IST's alliance predominance guideline states that growing and maintaining the therapeutic alliance takes priority over the therapist's hypothesis and plan, and specifically over the principle of application depicted by the matrix. The IST therapist seeks to have both parties explicitly on board with the direction of therapy and exercises great care with this until or unless the efficacy or integrity of the therapy is fundamentally compromised.

If there is a split alliance in which one partner has a good alliance and the other has a poor alliance with the therapist, the therapist seeks to balance this by being empathic and finding common purpose, if necessary, meeting individually to accomplish this. If there is a rupture of the alliance, the therapist works quickly to repair it, as it has been suggested that an alliance not soon repaired may end the therapy prematurely (Pinsof, 1995). Research by Goldsmith (2012) tracked 150 couples and found the following: Statistically significant ruptures of the alliance occurred at some point in the treatment of over 50% of couples; ruptures occurred equally in all phases of therapy (early, middle, and late); unrepaired ruptures were associated with proximal terminations; and couples with ruptures that were repaired tended to have better outcomes than couples who never had ruptures. It is hypothesized that the repair of ruptures builds trust with the therapist, thus strengthening the alliance, a key component of change.

Table 14.1 (Breunlin et al., 2011) contains the operational guidelines, as well as important attitudinal guidelines, that influence the practice of IST with couples.

The Decision to Stop Therapy

The decision to stop couple therapy is complex and idiosyncratic. The partners may come to the decision that they are ready to stop for a multitude of reasons: Their problems are fully resolved; their problems are partially, but suffi-

TABLE 14.1. Integrative Systemic Therapy Guidelines

1. The problem-centered guideline	All interventions should be linked, in some way, to the client system's presenting problems or concerns.
2. The strength guideline	Until proven otherwise, it is assumed that the client system can use its strengths and resources to lift constraints and implement adaptive solutions with minimal and direct input from the therapist.
3. The social justice guideline	Posits that the therapist attends to cultural contexts of membership (intersectionality), inclusion and social justice issues at each step of the IST essence diagram.
4. The assessment and intervention "inseparability" guideline	Assessment and intervention are two inseparable and co-occurring processes that span the course of therapy and lead to increasingly refined hypotheses and therapeutic plans that facilitate problem resolution.
5. The sequence replacement guideline	The primary task of the therapist is facilitating the replacement of the key problem sequences with solution sequences that eliminate or reduce the problem.
6. The empirically informed guideline	The practice of psychotherapy must be continually informed with empirical/scientific data in order to be maximally effective and efficient.
7. The educational guideline	Therapy is an educational process in which therapists give away their skills, knowledge, and expertise as quickly as clients can integrate them.
8. The cost-effectiveness guideline	Therapy begins with less expensive, more direct, and less complex interventions and moves to more expensive, indirect, and complex interventions as needed.
9. The interpersonal guideline	When possible and appropriate, it is always better to do an intervention, regardless of its nature, within an interpersonal as opposed to an individual context.
10. The temporal guideline	Therapy generally begins with a focus on the here-and-now and progresses to a focus on the past as more complex and remote constraints emerge within the therapy.
11. The failure-driven guideline	Therapeutic shifts occur when the current intervention fails to lift constraints sufficiently to permit implementation of the adaptive solution to the presenting problem.
12. The alliance-priority guideline	Growing, maintaining, and repairing the therapeutic alliance takes priority over the principle of application (planning matrix arrow) unless doing so fundamentally compromises the efficacy and/or integrity of the therapy.

Note. From Breunlin, Pinsof, Russell, and Lebow (2011). Copyright © 2011 John Wiley & Sons, Inc. Reprinted by permission.

ciently, resolved; their problems are not resolved but are accepted as an inevitable part of their life going forward; or the therapy has failed to resolve their problems, and they do not believe that more therapy will be productive.

There are several key considerations in deciding to terminate. Each partner must have a voice in the decision-making process; however, with couples in which one partner is done with the other partner and the therapy, the decision to terminate the couple therapy may be unilateral. Ideally, the "exiting" partner will continue in the therapy until the "hopeful" partner accepts the reality that the relationship and the couple therapy are over. However, frequently, the exiting partner is not willing to do that, and the couple therapy ends. At that point, it makes the most sense for the hopeful partner to engage in individual therapy, working toward acceptance and moving on with their life (see also Chapter 21 on divorce, in this volume, by Lebow).

The second major termination consideration is that the termination process ideally involves a review of the therapy and reflection on what has changed and what has not changed. Third, an explanatory narrative of change and lack of change needs to be elaborated. This narrative needs to include hypotheses about why certain things have changed and why other things have not changed. Last, there needs to be a plan for the future with at least two components. The first component involves a plan for how the partners will deal adaptively with their triggers and problem sequences when these occur. The second addresses the conditions under which they might seek therapy (couple, individual, or family) in the future. Articulating criteria for seeking help again at the end of an episode of therapy attempts to ensure that the partners will not turn to therapy prematurely and shortchange their own resources ("Work on the problems with the skills you have learned in this episode"), but also that they will turn to therapy when they are unable to resolve their issues on their own. As couple therapists at the end of therapy, we say, "Good-bye for now."

MECHANISMS OF CHANGE

The primary mechanism of change is the successful implementation of a solution sequence. That success, however, is almost always impeded by the presence of one or more constraints. Change takes place when the couple lifts those constraints through their collaboration with the therapist employing interventions selected from relevant planning metaframeworks. Constraints can sometimes be intractable, which means they can't be lifted. An example of an intractable constraint is a chronic illness. The partner with the illness must learn to cope with the limitations imposed by the illness, and the well partner must accept that the quality of life for each partner and for the relationship has been compromised. In some relationships, the well partner cannot tolerate these compromises and the relationship ends in divorce, or the couple stays in a chronically conflictual or emotionally disengaged relationship. For couples who seek and find acceptance in the face of an intractable constraint, the relationship can still be viable and potentially stronger and more rewarding.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

IST's versatility renders it applicable to just about any presenting concern. That versatility requires a comprehensive and complex approach that integrates much of the extant knowledge of couple therapy. This challenges the therapist to learn to work in a variety of ways. Because IST is an integrative approach, the therapist generally values breadth of knowledge and skill. For example, in the same case, a therapist might choose to employ the speaker–listener technique, enact a softening from emotion-focused therapy, and offer an interpretation from object relations couple therapy. Of course, to use any of these interventions requires therapists to possess an adequate level of skill.

Still, IST therapists, like all therapists, are taught to know their limits of expertise and to not work beyond their scope of practice. They are also taught to refer a case to another therapist if that therapist possesses specialized training regarding a presenting concern. For example, a therapist contacted by a couple that includes a nonbinary partner deciding whether to have gender confirmation surgery may refer the case to another therapist whose specialty is working with transgender couples.

Empirical Outcome Evaluation

Empirically evaluating outcome in couple therapy is a complex task. Outcome from a clinical perspective must be determined by both quantitative and qualitative criteria. The presence of multiple clients and multiple issues makes the determination of outcome a process among the therapist, the partners, and the data. This process returns us to our epistemological pillar of partial, progressive knowing: There is no "definitive outcome"; rather, there is a fluid and changing complex of opinions and data, which together yield a multifaceted picture of change and client satisfaction.

The basis for empirically informing IST is the blueprint. It provides the process for introducing both information and interventions into the therapy. IST views each case as a single-case study, informed by partners' feedback and relevant bodies of knowledge. The blueprint empirically informs the process of therapy in two ways. First, the therapist draws on empirical findings about human problems and therapy methods that can be organized in blueprint components (hypothesizing, planning, conversing, and feedback). Second, IST encourages the use of standardized progress instruments (completed by couples) that provide empirical data on the progress of therapy that informs the therapist regarding the progress of therapy and how best to proceed (Pinsof et al., 2015).

As a broad-spectrum metaperspective, IST has not sought to demonstrate efficacy through randomized clinical trials of a manualized treatment. However, to date, two studies have supported the effectiveness of IST. In a naturalistic investigation of the first eight sessions of IST (then called Integrative Problem-Centered Metaframeworks [IPCM] therapy) with 125 couples, Knobloch-Fedders, Pinsof, and Haase (2015) found that IST was effective in treating problems of both individual functioning and relationship adjustment. A second, larger study (Pinsof et al., n.d.) in a randomized clinical trial examined the use of a progress research instrument, the Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2015) with over 700 clients in individual and couple therapy. Although this was not a manualized study of IST, the therapists in the study were trained in IST, and the cases were assigned to IST and IST-plus-STIC conditions. The results showed that IST-trained therapists were effective in treating individuals and couples with and without the use of the STIC and were significantly more effective with cases in which the therapist used the STIC system.

CASE ILLUSTRATION

The Clients

Judith, a 55-year-old White woman, was married at the age of 23 and divorced when she was 44. She has one daughter, Samantha, who was born when Judith was 35. Samantha, now 20, is attending college out of state. Judith's divorce coincided with her coming out. She is a successful divorce attorney. She lives in a large urban environment. Judith's parents are both in their early 80s and still living. Judith's mother, however, has mild dementia and still lives at home, with her husband being her only caregiver. Judith has an older brother and a younger sister.

Juanita is a 44-year-old woman of Mexican descent. Her parents immigrated to the United States when Juanita was 7 years old. Her parents preserved the traditions of their country of origin and spoke Spanish in the home. Juanita was raised in a predominantly Mexican community. She went to a high school with a diverse student body. She knew she was a lesbian from an early age but did not come out until her senior year, as she was afraid to face her parents' disapproval. Juanita attended 1 year of college. She dropped out to help support the family when her father lost his job and could not find another one. Juanita has five siblings, three older sisters and two younger brothers. Two of her sisters returned to Mexico in their 20s. Until she met Judith, Juanita had been single her entire life. She has worked for a parcel delivery corporation for many years as a driver.

The Couple

Judith and Juanita met through an online dating service, and their relationship deepened quickly. They soon became exclusive, and within 6 months, Judith invited Juanita to move in with her. Judith proposed a quid pro quo in which Juanita would quit her job and manage the household, including the provision of child care for Samantha. Juanita would have no financial obligations. Judith would provide the income for the household. When Juanita moved in, Samantha, age 6, took an immediate liking to her. The couple parented well together, shared many interests in common, had a good sex life, and integrated well into the local community, where they had many friends. While they enjoyed a long-standing relationship, they never had substantive conversation about the nature of their commitment or the possibility of marriage.

The Presenting Problem

Both women mourned Samantha's departure for college. Then Juanita began to go out for the evening without Judith once or twice per week.

At first, it was only for a few hours. Gradually, however, she stayed out longer, sometimes not returning until 2:00 A.M. Around midnight, Judith would begin to text Juanita, asking when she was coming home. She might send up to 10 texts. Sometimes Juanita would answer her texts and other times she would ignore them. As this pattern repeated, Judith became increasingly frustrated, anxious, and angry. Finally, she confronted Juanita and suggested couple therapy or separation. Juanita agreed to attend couple therapy.

The Initial Session: Defining the Problem and the Problem Sequence

Following a review of the administrative issues, a discussion of confidentiality, and a brief description of IST, the therapist asked the couple for their views about what led them to seek therapy. The transcript below is an example of how an IST therapist uses the blueprint to define the presenting problem and problem sequence:

THERAPIST: Could you each share with me what brings you here today? Either of you can start.

JUDITH: Okay. We are drifting apart. We've been through a lot over the years, but I feel we are as close to ending our relationship as we have ever been.

THERAPIST: This sounds like a very distressing matter. What do you see happening in the relationship that makes you say that?

JUDITH: Well, my daughter, Samantha, left for college in September. Then Juanita started going out some evenings. [Using the development metaframework, the therapist hypothesizes that Samantha's departure constituted a life cycle transition that may have destabilized the couple.] At first it was just for a few hours, but then she'd stay out later and sometimes not come home until very late. Around midnight, I would send her a text and ask when she'd be home. Sometimes she'd respond and sometimes she'd ignore the text. I felt concerned and then afraid. I don't mind her going out, but it seems like common courtesy to respond to my texts.

JUANITA: Look, I'm in a bar talking to people. It's a total drag to keep looking in my purse to see if you texted me. Besides, you should just chill. I'm a big girl and I can take care of myself. Why don't you come with me?

JUDITH: (*snidely*) I think I am past my bar-hopping days. [Using the development metaframework, the therapist hypothesizes that the 11-year age difference might be straining the relationship.]

THERAPIST: I hear there is a lot of emotion and tension between the two of you when Juanita is out for the evening. Can you also share how you experience the time before she leaves and what it's like when she gets home? [The therapist expands the problem sequence.]

JUANITA: The tension starts to build hours before I leave. I used to tell her I was going out, but that just made her stonewall me. Now, I just leave.

JUDITH: You can cut the tension in the air with a knife. I want to ask if she's going out, but I don't want to start a fight.

THERAPIST: I am sorry to hear that your days together are tarnished by this issue. And when Juanita gets home?

JUANITA: Judith is in a funk. She says she can't sleep when I'm out, so she is on the sofa when I walk through the door. It's the same thing every time: "Why didn't you answer my text?" Lately, there's sarcasm, like "Why don't you have the decency to answer my text?" [The integrative nature of IST is illustrated here: Using Gottman's typology of the four horsemen (see Chapter 16 on the Gottman method, in this volume, by Gottman & Gottman), the therapist hypothesizes that Judith's frustration has led her to escalate her response to Juanita's behavior from criticism to contempt.] We used to get into a big row, but now I just ignore her and go to bed. Oh, you should know we don't sleep in the same bedroom anymore. [Stonewalling is also a part of the sequence.]

THERAPIST: Having this pattern repeat over and over is, no doubt, very distressing for both of you, but the circumstances could also trigger mistrust. I wonder if you have ever discussed issues of fidelity?

JUDITH: Sure, I don't think anything is happening now, but it's just a matter of time before someone goes after her.

This is an example, common in couple therapy, when the presenting problem and the problem sequence are one and the same. The problem sequence can be stated as: Every day is unstable because Judith doesn't know whether Juanita will go out. This creates a constant state of tension. When Juanita does go out, there is no agreement on the parameters of the evening. Judith feels alone and insecure. Finally, Judith sends a text that Juanita sometimes ignores. Judith grows more anxious and sends more texts. When Juanita arrives home, they may have an angry exchange, and both go to bed upset.

To create a solution sequence, the therapist shifts from hypothesizing and reading feedback to planning. Consistent with the temporal guideline to initiate therapy focusing on the present and using action, the therapist opens the action planning metaframework and selects a strategy to have the women talk directly to each other using the intervention of enactment. The goal of the enactment is to construct a solution sequence that will eliminate all or part of the problem sequence. The partners have a hard time talking. Their communication is circuitous, and their capacity for problem solving seems limited. The therapist offers a suggestion that, as a first step, they modify the texting aspect of the problem sequence by routinizing it. They agree and Judith agrees to text just once, and Juanita agrees to answer it and report when she is planning to get home. Troubleshooting the structure of the intervention reveals no obvious flaws in it, so the couple commits to implement it.

Subsequent Sessions

In the next session, the partners glumly report that they only used the solution sequence once. Finding no flaws in the structure of the solution sequence, the therapist decided to move to the next step on the essence diagram and inquire about constraints.

THERAPIST: What do you think kept the new arrangement from working?

JUANITA: If you want to know the truth, I didn't want to answer her text. I feel like I have been at Judith's beck and call ever since I moved in with her. I practically raised Samantha and kept the house while she got to work, and I got no thanks for it. Now that Samantha is gone, I want to do my own thing and I don't want Judith looking over my shoulder. For years she has treated me like a Mexican housekeeper, and I resent it.

THERAPIST: Juanita, I admire your courage for bringing up these issues. Judith, have you heard these concerns before?

JUDITH: Juanita, I am sorry you feel that way. Why have you been keeping this to yourself?

JUANITA: You have all the power in this relationship. I was afraid that you would ask me to leave if I told you how I feel.

JUDITH: You were afraid I would ask you to leave?! You are 11 years younger. You are gorgeous. You are the first woman with whom I have had a relationship. I had no idea what I was doing. I had a child and feared you wouldn't want that burden. I went to bed many nights fearing our relationship was doomed.

THERAPIST: It seems like you both feared losing the relationship. All that you just described could breed considerable anxiety.

JUDITH: I never saw myself as an anxious person, but when you put it that way, I'd have to say that I constantly have a low-grade anxiety about the viability of our relationship.

THERAPIST: Late at night, when you are alone, and Juanita is out—these are circumstances that could raise your anxiety. I wonder if that anxiety contributes to the number of texts you end up sending to her.

JUDITH: That makes sense.

The feedback provided in this brief exchange and further conversation generated clinical material for hypothesizing about a complex web of constraints that kept them from implementing the solution sequence. The development and organization metaframeworks suggested constraints that would have to be prioritized and lifted sequentially. This work would be the subsequent focus of therapy.

First, there were constraints of development. They struggled to make the macro transition of Samantha's departure for college. It unleashed in Juanita a yearning for freedom. She had always felt one down because Judith was older, more established, and financially secure, and Juanita was financially dependent on her. Rather than use the transition to negotiate a better arrangement with Judith, Juanita exercised a version of autonomy (going out and not responding to texts) that was destined to distress the relationship.

Second, the couple's relational development had not prepared them to make the changes they would need to make to become an "empty nest couple." Wynne (1984) argued that relationships pass through the stages of learning to communicate and problem solve before they have the ability to renegotiate the nature of the relationship through the stage he called "mutuality." Judith and Juanita, the therapist hypothesized, were constrained from renegotiating a post-Samantha relationship without significant help because they had not developed the communication and problem-solving skills that would support the ability to do so. Third, the age difference also served as a constraint. Judith felt too old for the bar scene; therefore, she did not go out with Juanita, and she feared that Juanita might find someone younger. Juanita admired Judith's maturity but also bristled when Judith would suggest what she should do.

The organization metaframework revealed a power differential between the women. Because Judith had a lucrative career, owned the home, and had retirement savings, she was secure. If they broke up, Juanita would be in a precarious financial position. While Samantha viewed Juanita as one of her mothers, Judith had custody and made all important decisions about Samantha. This also made Juanita feel "less than."

The therapist also opened the culture metaframework. Over the years, except for Mexican food, the couple had done little to reflect Juanita's Mexican heritage in the home. The couple lived in a predominantly White, non-Hispanic community. Juanita felt isolated and had experienced micro aggressions in the community. As would become clear as the couple's communication improved, this tore at her identity and exacerbated the insecurity she felt about herself and the relationship.

Judith's anxiety constituted another constraint. To avoid the symptoms of anxiety, she avoided discussing important issues with Juanita. Her anxiety ebbed and flowed as life issues confronted her. Finally, Judith's family of origin constrained the stability of the relationship. Judith's parents struggled to accept her sexual orientation and choice of partner. Judith felt sad and guilty that she did not have a better relationship with her parents.

Lifting Constraints

The therapist explained constraint theory and expressed confidence that the couple could lift their constraints and solve their problem. The first strategy, drawn from the action planning metaframework, was to improve communication. The intervention was the speaker–listener intervention. The therapist taught them the procedure in session and, to facilitate mastery, proposed an experiment for the women to practice it at home. It was hard for them to do the experiment. It seemed that Judith's anxiety was causing avoidance. In keeping with the sequencing suggested by IST's guidelines for intervention that are represented on the Matrix, the therapist moved from the action planning metaframework (speaker–listener exercise) to the meaning/emotion planning metaframework and talked with Judith about her experience with the exercise. They developed a shared understanding that the anxiety was interfering and it would be important to address it. The interventions for the anxiety were drawn from cognitive-behavioral therapy. The therapist possessed these skills and was therefore able to do this work. Consistent with IST's interpersonal guideline, the work was done with Juanita present. Six sessions focused on Judith's anxiety in the context of the couple's communication. Judith and Juanita worked together to create a hierarchy of challenging conversations. Working from the least to the most challenging, they role-played each scenario. As this work progressed, the women began to have spontaneous conversations that did not make Judith anxious. The reduction in Judith's anxiety removed a constraint to their communication and allowed for continued and more effective work on communication skills and problem solving.

The case took an important turn when Juanita talked about feeling financially vulnerable, since she had no assets. Judith agreed that something needed to be done. Subsequently, Judith put Juanita on the deed to the house and transferred financial assets to her that reflected Juanita's many years of caregiving for Samantha. Juanita invested the money and felt more secure about her future. This change in ownership and asset allocation addressed some of the constraints of organization and development.

Juanita gradually reduced the frequency of her outings and was always home at a reasonable hour, and Judith stopped texting her. The original problem sequence had been resolved. The couple requested that therapy continue because they wanted to talk about getting married. A constraint to marriage had always been the tepid acceptance of their relationship by both families of origin. After much discussion, they both agreed to have each set of parents attend several family therapy sessions to discuss their life choices. In IST parlance, the therapist would bring the parents into the direct client system. The therapist coached Judith and Juanita on how they would approach their parents. While testy at times, the sessions with both sets of parents were ultimately constructive and both said they would bless a marriage.

CONCLUDING COMMENTS

Therapists inevitably gravitate toward a way of engaging in therapy that fits for them. For many, this is a single, specific model of couple therapy that they master. Those who are drawn to an integrative approach see the benefits of having a multifaceted perspective and multiple pathways for intervention. They have a penchant for selecting concepts and interventions based on the unique needs and circumstances of their clients. IST offers a perspective for doing just that. It is an open conceptual system that is infinitely adaptable to modification and the adoption of new ideas. The field of couple therapy will continue to advance. IST is built to embrace these innovations while retaining its systemic rigor and integrative flexibility.

SUGGESTIONS FOR FURTHER STUDY

Chambers, A. L. (2019). African American couples in the 21st century: Using integrative systemic therapy (IST) to translate science into practice. *Family Process, 53,* 595–609.

Pinsof, W. M. (2018). *Integrative systemic therapy with couples* [DVD]. www.apa.org/pubs/videos/4310984.html.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J. L., Rampage, C., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families.* Washington, DC: APA Books.

Russell, W. P., & Breunlin, D. C. (2019). Transcending models and managing complexity: Suggestions from integrative systemic therapy. *Family Process, 58*(3), 642–655.

Russell, W. P., Breunlin, D. C., & Sahebi, B. (in press). *Integrative systemic therapy in practice: A clinician's handbook.* New York: Routledge/Taylor & Francis.

REFERENCES

Aponte, H. J., & Kissil, K. (Eds.). (2016). *The person of the therapist training model: Mastering the use of self.* New York: Routledge

Bateson, G. (1972). *Steps to an ecology of mind.* New York: Ballantine Books.

Boszormenyi-Nagy, I., & Spark, G. M. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy.* New York: Harper & Row.

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Aronson.

Breunlin, D. C. (1999). Toward a theory of constraints. *Journal of Marriage and Family Therapy, 25,* 365–382.

Breunlin, D. C., Pinsof, W., & Russell, W. P. (2018). Integrative systemic therapy. In J. Lebow, A. Chambers, & D. Breunlin (Eds.), *Encyclopedia of couple and family therapy.* New York: Springer.

Breunlin, D. C., Pinsof, W., Russell, W. P., & Lebow, J. (2011). Integrative problem-centered metaframeworks therapy: I. Core concepts and hypothesizing. *Family Process, 50*(3), 293–313.

Breunlin, D. C., Schwartz, R. C., & Mac Kune-Karrer, B. M. (1992). *Metaframeworks: Transcending the models of family therapy.* San Francisco: Jossey-Bass.

Breunlin, D. C., Schwartz, R. C., & Mac Kune-Karrer, B. M. (1997). *Metaframeworks: Transcending the models of family therapy* (rev. ed.). San Francisco: Jossey-Bass.

Chambers, A. L. (2012). A systemically infused integrative model for conceptualizing couples' problems: The four-session evaluation. *Couple and Family Psychology: Research and Practice, 1,* 31–47.

Chambers, A. L., & Lebow, J. (2008). Common and unique factors in assessing African American couples. In L. L'Abate (Ed.), *Toward a science of clinical psychology: Laboratory evaluations and interventions* (pp. 263–281). Hauppauge, NY: Nova Science.

Fishbane, M. D. (2007). Wired to connect: Neuroscience, relationships, and therapy. *Family Process, 46,* 395–412.

Fishbane, M. D. (2013). *Loving with the brain in mind: Neurobiology and couple therapy.* New York: Norton.

Fishman, H. C. (2012). *Intensive structural therapy: Treating families in their social context.* New York: Basic Books

Framo, J. L. (1992). *Family-of-origin therapy: An intergenerational approach.* New York: Routledge.

Fruzzetti, A. E., & Payne, L. (2015). Couple therapy and borderline personality disorder. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 606–634). New York: Guilford Press.

Goldsmith, J. (2012). *Rupture-repair events in couple therapy: An exploration of the prevalence of sudden drops in couple therapy alliance, and their impact on therapy progress.* Doctoral dissertation, Miami University. https://etd.ohiolink.edu.

Hodge, D. R. (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46,* 203–214.

Knobloch-Fedders, L. M., Pinsof, W. M., & Haase, C. M. (2015). Treatment response in couple therapy: Relationship adjustment and individual functioning change processes. *Journal of Family Psychology, 29*, 657–666.

Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Lebow, J. L. (1997). The integrative revolution in couple and family therapy. *Family Process, 36,* 1–17.

Lebow, J. L. (2014). *Couple and family therapy: An integrative map of the territory*. Washington, DC: American Psychological Association Press.

McCallie, M. S., Blum, C. M., & Hood, C. J. (2006). Progressive muscle relaxation. *Journal of Human Behavior in the Social Environment, 13*(3), 51–66.

McGoldrick, M., Gerson, R., & Petry, S. S. (2008). *Genograms: Assessment and intervention*. New York: Norton.

Nelson, M., & Hunt, Q. (2016). Sensate focus. In J. Carlson & S. B. Dermer (Eds.), *The SAGE encyclopedia of marriage, family, and couples counseling* (pp. 1494–1497). Thousand Oaks, CA: SAGE.

Pinsof, W. M. (1995). *Integrative problem centered therapy: A synthesis of biological, individual and family therapies*. New York: Basic Books.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., & Lebow, J. L. (2011). Integrative problem centered metaframeworks (IST) therapy: II. Planning, conversing, and reading feedback. *Family Process, 50,* 314–336.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J. L., Rampage, C., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples and families*. Washington, DC: APA Books.

Pinsof, W., Tilden, T., & Goldsmith, J. (2016). Empirically informed couple and family therapy: Past, present, and future. In T. L. Sexton & J. Lebow (Eds.), *Handbook of family therapy* (pp. 500–516). New York: Routledge/Taylor & Francis Group.

Pinsof, W. M., Zinbarg, R. E., He, Y., Goldsmith, J., Latta, T., & Hardy, N. (n.d.). Untitled unpublished manuscript, The Family Institute at Northwestern University, Evanston, IL.

Pinsof, W. M., Zinbarg, R. E., Shimokawa, K., Latta, T. A., Goldsmith, J. Z., Knobloch-Fedders, L. M., . . . Lebow, J. L. (2015). Confirming, validating, and norming the factor structure of Systemic Therapy Inventory of Change Initial and Intersession. *Family Process. 54,* 464–484.

Rampage, C. (2002). Marriage in the 20th century: A feminist perspective. *Family Process, 41,* 261–268.

Real, T. (1997). *I don't want to talk about it: Overcoming the secret legacy of male depression*. New York: Scribner.

Real, T. (2002). *How can I get through to you?: Closing the intimacy gap between men and women*. New York: Fireside.

Russell, W. P., & Breunlin, D. C. (2019). Transcending therapy models and managing complexity: Suggestions from integrative systemic therapy. *Family Process, 58,* 641–655.

Russell, W. P., Pinsof, W. M., Breunlin, D. C., & Lebow, J. L. (2016). Integrative problem centered metaframeworks (IPCM) therapy. In T. Sexton & J. Lebow (Eds.), *Handbook of family therapy* (pp. 530–544), New York: Routledge.

Schwartz, R. (1995). *Internal family systems therapy*. New York: Guilford Press.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York: Norton.

Siegel, D. J. (2012). *The developing mind: Toward a neurobiology of interpersonal experience* (2nd ed.). New York: Guilford Press.

Stanton, M. (2009). The systemic epistemology of family psychology. In J. H. Bray & M. Stanton (Eds.), *Handbook of family psychology* (pp. 5–20). Oxford, UK: Wiley-Blackwell.

Stanton, M., & Welsh, R. (2011). *Specialty competencies in couple and family psychology*. New York: Oxford University Press.

Walsh, F. (2010). Spiritual diversity: Multifaith perspectives in family therapy. *Family Process, 49,* 330–348.

Wynne, L. C. (1984). The epigenesis of relational systems: A model for understanding family development. *Family Process, 23,* 297–318.

CHAPTER 15

Therapeutic Palette Integrative Couple Therapy

Peter Fraenkel

BACKGROUND

The therapeutic palette integrative approach (TPIA—in this chapter referred to as the TP) is a set of principles for selecting among the wide variety of existing theories and their associated techniques to design a comprehensive, flexible treatment for couples. The reader interested in the specific theories and associated practices that TP utilizes can find those presented in more detail in other chapters of this *Handbook*. In TP, therapy is viewed as a creative act in which the therapist systematically engages a wide range of science- and craft-based principles and practices in collaboration with couples' perspectives on what they most need and are ready to engage at a particular moment in order to promote change.

The impetus for TP initially grew out of my experience teaching graduate and postgraduate courses, beginning in the early 1990s, in family and couple therapy at the Ackerman Institute for the Family and then at the City College of New York. By the time students encountered the third major school of family and couple therapy, they inevitably became anxious about how to decide which approach to use, or how to combine them (Fraenkel & Pinsof, 2001). Some in the field advocated that therapists should select the approach that best matches their "worldview" (meaning mostly their perspective on the process of change) and their personal proclivities (e.g., for being directive and action-oriented vs. less directive and more exploratory and insight-oriented; Simon, 2003), or that practitioners formulate their own idiosyncratic integration. This guidance seemed both pragmatically and ethically problematic, as some trainees are not as skilled or interested as others in the area of theory building (and may remain unclear about how to formulate their own integration, and might do so unsystematically). This meant that the effectiveness and comprehensiveness of a couple's treatment would depend on the therapist's personality and comfort with particular styles of intervention, rather than based on the science of couple functioning, carefully conceived systemic theories and interventions, and the history of the craft of couple therapy accumulated over decades (Doherty, 2012). Yet in the early 1990s, although there was a beginning movement toward integration (Lebow, 1987, 1997) that paralleled the integrative psychotherapy movement in individual psychotherapy, there were few well-articulated integrative approaches in the literature (with some notable exceptions; Gurman, 1981), and none that incorporated perspectives and practices from most of the well-known approaches. Pinsof's (1995) integrative problem-centered therapy was a highly influential approach, and I was developing my approach simultaneously (Fraenkel, 1997; Fraenkel & Pinsof, 2001).

The case for integrative approaches in couple and family therapy has been made in detail elsewhere (Fraenkel, 2009, 2017; Lebow, 2014).

Key considerations include the following: First, even the most rigorously studied single-theory approaches to couple therapy, such as cognitive-behavioral couple therapy (CBCT) and emotionally focused couple therapy (EFT), do not result in sustained clinically positive outcomes for a substantial number of couples, especially when these treatments are conducted outside of highly controlled academic/laboratory settings (Bradbury & Bodenmann, 2020). Furthermore, randomized clinical trial studies (RCTs) have not been conducted to establish the efficacy of one model over another (Bradbury & Bodenmann, 2020), and meta-analytic reviews of RCTs in psychotherapy more generally do not demonstrate such differences (Wampold, 2001). As Davis, Lebow, and Sprenkle (2012) write, "Although reliable differences in treatment models may be discovered, we believe it is unlikely that one model will be shown to be universally more effective than others" (p. 37). Anecdotal evidence from outcomes of nonintegrative approaches finds that "nothing always works" (Pinsof, 1995), and an integrative therapist can move from one approach that has plateaued in its usefulness to another that addresses the couple's additional needs.

Second, couples often have their own theories about the source of their problems and preferences for how they would like the therapist to work with them (Davis et al., 2012). Some may have had unsuccessful treatment with a certain approach (e.g., one focused on detailed exploration of family-of-origin experiences and intrapsychic issues) and request a different approach (e.g., more action/skills oriented, or vice versa; Fraenkel, 2009, 2019). The couple's cultural background can also influence their preferences for a specific approach and desire to avoid others. For instance, those who have concerns about sharing details of their family-of-origin struggles ("airing the family's dirty laundry") may wish for an approach centered on here-and-now interactional challenges (Boyd-Franklin, 2003; Falicov, 1998). The integrative therapist well versed in different approaches can match the initial approach taken to the preferences of the couple, engaging them later in another approach when they become open to it.

Third, couples' conflicts are typically caused by or associated with multiple factors, including problematic beliefs and perceptions, unpleasant emotions, dysregulated physiological arousal, and dysfunctional interactional behavior. In addition, the sources of these factors include rigid, present-oriented patterns that have gained functional autonomy, difficult experiences and problematic maps of relationships from partners' respective pasts and cultural contexts, and often divergent ideas about the future. An integrative approach that provides different theoretical vantage points to guide assessment and intervention is arguably superior to an approach that focuses solely or mostly on one set of factors (see Snyder & Mitchell, 2008, for a similar perspective in their pluralistic developmental approach).

The literature on integrative approaches has specified four major forms of integration (Norcross & Alexander, 2019): theoretical integration (combining two or more theories into a superordinate theory), technical eclecticism (assembling a menu of empirically supported techniques drawn from different models and matching those techniques to a client's issues), common factors (largely centered on therapist interactional qualities such as warmth, genuineness, empathy, as well as generating hope and offering a coherent plan and structure for therapy), and assimilative integration (with one model forming the theoretical and practical base and integrating ideas and practices from other approaches). TP represents a fifth form of integration, multiperspectivalism, in which the therapist moves among entire theories and their associated practices as if viewing the couple and their context through different lenses (Fraenkel, 2009).

TP is aligned with the common-factors perspective in highlighting the importance of attending to couples' perspectives on their problems and tailoring the approach taken to match their predilections; in focusing greatly on therapist behaviors that create and maintain the therapeutic alliance; and in recognizing the conceptual and technical similarities across different models (Davis et al., 2012; Sprenkle, Davis, & Lebow, 2009). Whereas the current state of common-factors research focuses largely on therapist qualities and the therapeutic relationship, TP also proposes that there are discernable common factors, elements, and dimensions of theory and intervention (see a similar point in Benson, McGinn, & Christensen, 2011; Pinsof et al., 2018; see Chapter 14 on integrative systemic therapy, in this volume, by Breunlin, Russell, Chambers, & Solomon). These include the elements and dimensions discussed below as the "primary colors" of TP, as well as many common goals and activities. Common therapy goals across models include determining the patterns of behaviors, thoughts, and emotions that limit couples and lead to unhappiness; helping the couple find new ways of interacting and seeing each other that lead to greater happiness (or realizing that one or the other partner cannot change enough for both to be happier); and helping partners move from an "I versus You" model of relationship to one in which they contribute to and develop an identity as a "We"—a couple-level identity and narrative that accepts and utilizes inevitable differences, in the spirit of attaining harmony.

Likewise, when the landscape of models is viewed through a wider perspective, common therapeutic activities/interventions across all models include questions and comments (in some models, based on observations, in others, based only on the couple's narratives) about sequences of behavior, thought, and emotion (including physiological states); questions and comments about couples' existing resources that may be underutilized; witnessing and empathizing with each partner about their suffering; suggesting new ways to see each other; drawing out, and understanding the source of, unexpressed feelings and arousal states; and suggesting new, preferred ways to interact.

The heuristic metaphor of the therapeutic "palette" suggests that the therapist draws on a set of "primary colors" or organizing themes based on the stated and interactionally demonstrated needs of the couple at any one moment, as well as their preferences for how the therapist should work with them. Therapy progresses much as a painter works on one part of a canvas, then another, gradually completing the painting but not necessarily completing one section before moving to another. Rather, the therapist works in one area of the couple's lives and problems and may switch to another as opportunities emerge in the trialogue. The three "primary colors" are *time frame focus* (theory and interventions that address the present interactions and partners' intrapsychic experiences vs. those that address the link between each partner's past/family of origin and the present relationship vs. those that address the couple's visions of their future); *degree of directiveness* (from low to high); and *change entry point* (choosing to focus on cognitions/beliefs/narratives, emotions, physiological arousal/emotion modulation, or interactional behavior).

In many cases, couples initially present in some form of crisis, with problematic communication styles that limit their ability to resolve the crisis, and the therapist suggests an initial phase of teaching them skills for improving communication and other aspects of interaction (present focus, highly directive, behavioral and physiological/emotion modulation entry points). Once the couple is interacting more satisfactorily and is in less distress, the therapist may suggest exploring the respective family and culture-of-origin experiences that resulted in conflict (past-to-present focus, less directive, cognitive/memory entry point).

However, other couples may not request or require help changing problematic forms of interaction, and instead seek an opportunity to discuss long-standing misunderstandings or traumatic events and desire a more insight-oriented approach that explores their history and the link between their history and their respective family-of-origin and culture-of-origin experiences. In some of these couples, both partners may be in their own respective individual therapies and want the couple therapist to help them weave together their insights into an understanding of the challenges experienced in the relationship. However, over time, it may become apparent that what had kept them from openly discussing these past traumas and understanding one another's family-of-origin-based "vulnerabilities" (Scheinkman & Fishbane, 2004) is a conflict avoidant style, and some training in structured communication skills can then be useful.

The TP therapist often moves fluidly among time frames, level of directiveness, and change entry point within one session. For instance, after being taught structured, research-supported communication and problem-solving skills drawn from CBCT (see Chapter 3 on cognitive-behavioral couple therapy, in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), one partner may reflect on how different these ways of talking about problems are from the constant conflict she witnessed in her parents' relationship. This is a propitious moment to explore each partner's experiences in their family of origin to understand their internalized maps of couple relationships and help them differentiate their new learnings from that past. This exploration typically leads partners to express long-held painful emotions. From the perspective of perceptual and social psychology, attunement to these openings is about noticing "affordances"—the opportunities available to a person or other living organism for action in their environment (Gibson, 1979; Good, 2007). In the therapeutic environment of the couple, therapists' capacity to perceive affordances depends on the number of ideas they hold about couple challenges and solutions. Sensitivity to affordances allows the therapist to be more fully *responsive*, a quality found central to the therapeutic alliance (Stiles, Honos-Webb, & Surko, 1998), and strengthens clients' perceptions of the credibility of the treatment (Constantino, Coyne, Boswell, Bes, & Visla, 2018).

Three principles guide decisions about which approach to use in the moment. First is the health/resource perspective—determining whether what the couple is feeling, thinking, and doing supports their adaptiveness and coping abilities, emotional comfort and safety, and mutual pleasure, and the degree to which they have existing underutilized resources available or need more guidance.

The second principle is balancing support of the existing system with introducing novelty. All systems exist in an ongoing dialectic between morphostasis (maintaining the existing form) and morphogenesis (needing to change; Steinglass, 1987). Life cycle transitions and unexpected, idiosyncratic events such as illness, early death of a parent, child, or other family member, and job loss force couples to adapt and change, and they may not have existing coping resources to negotiate these imperatives for novelty (Bodenmann & Randall, 2020).

This principle also guides when the therapist shifts from one change entry point to another. For instance, with a highly intellectualized couple who rarely expresses feelings, the therapist may first connect with them around their thoughts, constructions, beliefs, and narratives, and then ask them to talk about emotions. With a couple that repeatedly recounts their history of eroding passion, the therapist eventually encourages them to try new activities to regenerate sexual passion. In contrast, an emotionally volatile couple whose style is quickly to jump to attempted solutions to concrete problems may require the therapist to help them slow down and examine thoughts and feelings to address the underlying relational dynamics (usually around power and connection) that result in insufficient resolutions to specific issues.

The third principle is that of economy. Most couples have limits on time and money for therapy, and often present with some degree of emotional urgency to create change. The therapist therefore strives to stimulate change in the shortest amount of time, while recognizing that some couples may require longer-term support.

This "going with the flow" approach differs from more structured integrative approaches, in which the therapist works primarily from one theoretical perspective for several sessions, then systematically moves to the next perspective (Nielsen, 2016; Scheinkman, 2008; see also Chapter 14, in this volume, by Breunlin et al.). Drawing on a musical analogy, TP is conducted more like a jazz tune, with time frame focus, level of directiveness, and change entry point as themes or principles, but with improvisation within the themes as opposed to a more structured, sequenced, integrative approach constructed in the form of a classical symphony with several discreet movements.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

As an integrative, multiperspectival approach, TP draws on a wide range of clinical theories and research findings to conceptualize healthy and dysfunctional couple relationships. These are only briefly described below, as the details of these familiar, specific positive qualities and challenges are covered in other chapters of this book. I describe in more detail challenges that I conceptualize more uniquely—around temporal differences between partners, and a theory of emotion modulation/regulation.

Healthy Couple Relationships

At the broadest level, healthy couples engage in kindness, compassion, collaboration, effective problem solving, pleasurable activities, and mutual responsiveness. Given the cultural differences in beliefs about intimate bonds, it may be presumptuous to advance a unified, prescriptive description of the nature of romantic love. However, based on a wide range of clinical theory and research (largely covered in other chapters of this book), a view of healthy couplehood and romantic love is herein proposed. Love is borne from initial attraction in some admixture of physical attraction, shared intellectual and aesthetic interests and curiosity about the world; shared social, spiritual, religious, or ethical values; curiosity, excitement, and enjoyment about differences between the self and the other, as well as caring about the well-being of one another. As the relationship progresses, movement from a "Me and You" relationship to one of "We" becomes important—a sense of shared identity that does not subsume the individual identities of each partner but adds another conjoint layer to the couple. This "We" identity plays a role in a wide range of decisions and necessary compromises by each partner, such as how to spend time, the nature of leisure activities, how to parent, choices about shared purchases, and many others. The degree to which partners experience a sense of We-ness is significantly correlated with relationship satisfaction and stability (Buehlman, Gottman, & Fainsilber Katz, 1992).

Attaining a sense of We-ness requires each partner to get to know the other's mind—a process termed "mentalization" (see Chapter 8 on mentalization, in this volume, by Bleiberg, Safier, & Fonagy). Knowing one another's minds—including how the partner views one—provides the space to find areas of commonality that become central to the We identity, along with acceptance of differences, which can also be part of the broader sense of We (as in "We are similar in these ways, we are different in these other ways, and we accept those differences"). A related process is attaining a degree of intersubjectivity (Benjamin, 2017), wherein shared understandings and feelings form the basis of the relationship that then recursively reshapes each individual's intrapsychic life, such that each partner's individual identity is reconstructed to include being part of a We. Similarly, Solomon (2017) suggests the importance of developing "relational self-awareness"—persons getting to know themselves and how they are in relationships, which is an ongoing process based on experiences in intimate relationships that can reshape the overall nature of the We. From an existential psychology perspective, love and intimacy require "social courage . . . the courage to relate to other human beings, the capacity to risk one's self in the hope of achieving meaningful intimacy" (May, 1975, p. 17). Partners need to continue to attend to the quality of the relationship and put energy into it. May writes, "It is the courage to invest one's self over a period of time in a relationship that will demand an increasing openness" (p. 17).

Romantic love also requires behaviors that build and maintain trust (Gottman, 2011)—which, depending on the needs of each partner, can include ending friendships with ex-lovers or at least bringing those past partners into the joint friendship circle; restrictions on time spent alone with persons who might stimulate romantic or sexual desires and opportunities; and openness about one's whereabouts when apart and one's times for arriving home. Trust is sustained through acts that encourage emotional attunement and safety, such as listening empathically and compassionately to each other's upset about issues other than the relationship (and of course, about one's upsetting behavior in the relationship), and avoidance of aggression, intimidation, or other forms of undue, undesired forcefulness, including in sex. Over time, a deep, reliable friendship becomes a central part of an intimate couplehood.

Flexibility in each partner's expectations about the course and content of a life together is also important, as partners go through inevitable disappointments, changes in work, and other endeavors that may have financial or geographic repercussions for the couple, as well as illnesses and disabilities. Periodic refreshening of the couple's menu of leisure activities is necessary, as research suggests that couples who have a balance of regular activities that bring pleasure and occasionally introduce novel joint pursuits sustain more pleasure and satisfaction over time (Aron, Norman, Aron, McKenna, & Heyman, 2000).

Distressed Couple Relationships

Although certain sources of difficulty are shared across many couples, each couple constitutes a unique combination of challenges. As Snyder and Mitchell (2008) noted, "Couple therapists confront a tremendous diversity of presenting issues, marital and family structures, individual dynamics and psychopathology, and psychosocial stressors that characterize couples in distress" (p. 354). Each of these difficulties represents a target for intervention.

At the broadest level, dysfunctional, unsatisfying relationships are characterized by hurtful exchanges, a preponderance of negative expressed affect, and a lack of mutual responsiveness and care. At the interactional level, distressed couples engage in specific forms of dysfunctional communication—particularly, escalation, withdrawal, invalidation, and negative attributions/interpretations, and higher levels of criticism, contempt, and defensiveness. Partners do not regularly respond to each other's bids for attention, do not accept influence from one another, and engage in other problematic behaviors. Accompanying and often prompting these negative behaviors are high levels sympathetic physiological arousal (Fishbane, 2013).

Distressed couples typically struggle around broader relational themes such as power (at the extreme end, aggression, intimidation, and interpersonal violence), closeness and affection, respect and recognition, integrity, commitment, and trust. These struggles represent a combination of cognitive (negative attributions), emotional, and interactional difficulties, and are often infused by beliefs stemming from family of origin and by beliefs stemming from cultural backgrounds and social locations, such as gender.

Distressed couples also often struggle with a range of external stressors (Bodenmann & Randall, 2020), including occupational challenges leading to conflicts around work–life balance (Fraenkel & Capstick, 2012), financial difficulties, experiences of oppression based on partners' social locations, as well as various psychological disorders (e.g., depression, trauma, and overuse of alcohol or other substances).

TP also draws on my clinical theory about how partners' struggles often revolve around differences in their temporal behavior and beliefs about time (Fraenkel, 1994, 2011). Partners often differ in pace, punctuality, preferred or required daily and weekly rhythms (including bed and wake times), time perspective (with a dominant focus on the present vs. the future vs. the past), time orientation (degree of attention to structuring their lives by the clock and calendar), how they wish to allocate time to various activities (amount of intimate time together vs. time with the kids, with extended family and friends, for work, in solitary activities), and in their "projected life chronologies"—how they envision the time line of their preferred futures and goals. These differences are often an initial source of attraction (e.g., the fast-paced partner who finds the slow-paced partner calming, the slow-paced partner who finds the fast-paced partner exciting) but may over time become polarized, resented, and a major source of conflict. Temporal differences are sometimes explicitly experienced and described as a problem by partners, and sometimes operate under awareness but lead to conflicts about other issues such as finances (whether to spend more money in the present or save for the future, when to try to have a child, differences in the pace of sexual behavior).

TP also engages a theory about the way in which partners recruit one another, often unconsciously, to regulate or modulate and express their own emotions (Fraenkel, 2019). The seminal article by Don Jackson (1965) titled "Family Rules: Marital Quid Pro Quo" described how, early on, couples form an implicit, usually unspoken contract to distribute tasks and roles:

> When two people get together, they immediately exchange clues as to how they are defining the nature of the relationship; this set of behavioral tactics is modified by the other person by the manner in which he responds. . . . Quid pro quo, then is a descriptive metaphor for a relationship based on differences, and expression of the redundancies which one observes in marital interaction. (p. 591)

One aspect of this contract often seems to center on how partners will respond to each other's emotions; this is one frequently unrecognized factor in how partners select one another. Some partners may turn to the other to activate or "upregulate" them, while the other relies on their partner to "downregulate" or calm them. As noted earlier, this pattern of up- and downregulation is often related to a temporal polarity or complementarity, with the upregulating partner being more fast-paced, and the downregulating partner being more slow-paced. In distressed couples, these differences become greatly polarized and a source of conflict, wherein the slow-paced, downregulating partner resents the other for frequently trying to engage them in upregulating, excitement-oriented activities and conversations, and the faster-paced, upregulating partner resents the other for always trying to calm them down and engage in slower activities.

Likewise, one partner may be more comfortable expressing certain emotions (e.g., anger), and the other more comfortable expressing vulnerable feelings (e.g., anxiety or sadness), and each comes to rely on the other to express the feelings that are not as comfortable for them. In yet other couples, one partner may specialize in pointing out positive aspects of situations and expressing positive feelings, whereas the other specializes in pointing out a situation's shortcomings and expressing negative affect. Or one may take the stance of being "rational" and relying solely on logic to solve problems, whereas the other takes the role of expressing emotions—a pattern that has often been incorrectly attributed to inborn rather than socialized differences between men and women in cisgender heterosexual couples (Hare-Mustin, 1978; Jackson, 1965). In distressed couples, each partner often comes to push back on the other's manner of handling emotions, even though they may initially have been attracted by those selfsame orientations toward handling emotion. The phenomenon of projective identification may enter this broader pattern (see Chapter 7 about object relations, in this volume, by Siegel).

THE PRACTICE OF TP INTEGRATIVE COUPLE THERAPY

The Structure of the Therapy Process

The therapeutic relationship begins with the first phone call, which often now takes the form of a brief initial consultation, as couples often locate a therapist through viewing websites rather than through a trusted word-of-mouth referral. This first call provides an opportunity to briefly describe TP as a combination of action-oriented techniques that promote change and gaining insight into the nature and causes of the couple's difficulties. As many couples have had previous unsatisfying experiences in therapy—usually because there was too much time spent discussing feelings and history, and not on learning practical tools—the TP therapist emphasizes that direct guidance will be provided on interactional change such as communication and problem-solving skills and techniques to enhance intimacy. If possible, it is preferable to speak with both partners, either together or separately.

Both partners are invited to attend the first session, which is typically 50–60 minutes in length but may be 90–120 minutes if the couple is in crisis. Subsequent sessions are 50–60 minutes in length and are usually held weekly until the couple is "launched" into better patterns of functioning, at which time sessions may be biweekly or even monthly. The length of therapy is determined by the needs of each couple, with an average of 10–20 sessions. Briefer courses of therapy (four to six sessions) may be sufficient for less distressed couples or for nondistressed couples who seek skills to prevent serious relationship difficulties they witnessed in their families of origin or in friends' relationships. This time-limited, skills-oriented format is also useful for couples in which one partner does not believe in therapy and is reluctant to engage or does not want to explore family-of-origin experiences in depth. The TP therapist can describe the services offered as "not therapy, just learning some new tools for improving communication and getting along better."

On the other hand, after a period of weekly sessions in which conflict is reduced and new skills are acquired, some initially highly distressed and "last chance" couples may elect to engage in ongoing therapy for a year or more, often at a lower frequency of sessions, to maintain their gains. The therapist makes clear that "the door is always open," as couples may encounter new challenges over time and want to revisit the skills and ideas they acquired initially. Booster sessions have been shown to promote better long-term outcomes in distress prevention programs (Braukhaus, Hahlweg, & Kroeger, 2003).

Usually after three to four conjoint sessions, the therapist suggests an individual session with each partner. These sessions are confidential, providing each partner an opportunity to share information and feelings that they are not yet comfortable sharing with the partner, if at all. However, the couple is told that at the end of each of these individual meetings that the therapist will review with the partner what information would be useful to bring back to the conjoint format, and what information the partner wishes not shared (see also Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen). If the other partner is unaware of an ongoing extrarelational affair, the therapist requests that the partner end it, at least for the period of couple therapy, so as to bring energy and attention back to the primary relationship. The therapist does not disclose the affair to the other partner. If in an individual meeting a partner discloses occurrences of violence, or drug or alcohol overuse by the other partner, the therapist strongly suggests that these issues be raised conjointly.

Persons seeking couple therapy are often in their own individual therapy and may have been referred by an individual therapist. They also may be on psychotropic medication. The TP therapist asks for permission to speak with all other treating mental health professionals (and physical health professionals, if warranted) in order to work in a coordinated manner. If one or both partners appear to be struggling with significant untreated symptoms of anxiety, depression, or trauma that impair their social and/or occupational functioning, the TP therapist will evaluate whether couple therapy is likely sufficient to ameliorate these symptoms, or whether a referral is warranted for other forms of treatment.

TP provides readings for couples from the professional literature (on research findings about typical problem patterns of communication, other behaviors, and attitudes associated with better or worse outcomes, and support for the techniques used), as well as handouts that spell out the techniques taught in sessions. These readings provide opportunities to reflect further on the ideas and skills taught in sessions, as well as greater credibility for the foci of treatment and techniques used, enhancing the couple's perception of the therapist as a well-informed, trustworthy expert.

TP strongly holds that changes in interaction more often lead to changes in thoughts and emotions than the other way around, wherein insight is expected automatically to result in new action. Therefore, each session ends with suggestions about activities to "experiment with possibilities" (Fraenkel, 2019). As much as possible, these suggestions are based on research about behaviors found to promote greater satisfaction and coping, but the specifics of the activity and the language used to introduce them are often tailored to specific couples and their meaning systems.

For instance, in one couple, the wife complained that her husband rarely expressed affection toward her, did not even seem to enjoy seeing her or being in her presence, and was often more affectionate to their cats. The therapist reflected on a chapter he had sent them some weeks earlier about the importance of "getting a kick" out of one's partner (Fraenkel, 2001), and described Gottman's research on the power of statements of appreciation and admiration in relationship satisfaction and on the importance of responding to one's partner's "bids for attention." The therapist wondered if the wife was saying she wished to be more "seen and adored" by him. The wife said, "Exactly!" and her eyes moistened with tears. To the wife's surprise, the husband, who felt preoccupied by work, said that he frequently felt adoring toward her but did not express it. The therapist asked permission to imagine those moments from the husband's experience and wondered whether he would have flashes of adoring feelings that then quickly became submerged by the "weight of the world on [your] head and shoulders." The husband laughed and said that was "pretty much right!" Picking up the theme of the husband's love for the cats, and the wife's envy of that love, the therapist then reflected on how cats often signal affection by closing and opening their eyes,[1] and suggested that the husband could sometimes express his adoration in words, but other times, simply look at his wife with a smile and close and open his eyes, as if she were a cat. The therapist happened to have two cats and brought one to the computer screen to demonstrate this phenomenon, but as expected, the cat did not cooperate, leading to laughter all around. The wife also offered to help the husband realize when he was being grumpy and withdrawn, and that she desired some acknowledgment by using a signal, and they decided on "Purple Cat." The therapist humorously suggested that they could add some music to the signal and sang the chorus of Prince's song "Purple Rain" but substituted "cat" for "rain." These interventions created a moment of humor, and further strengthened the therapeutic alliance with the husband, who was being asked to do something small but challenging.

The Role of the Therapist

In TP, the therapist takes the stance of a collaborative expert and consultant who co-identifies problem patterns and the likely sources of those patterns ("assessment") and suggests interventions based on the research findings about variables that distinguish happy from unhappy couples, findings on the range of stressors that affect couples, and on techniques that have garnered research support.

However, the validity of this "nomothetic" body of information is always evaluated in terms of its applicability to the specific, "idiographic" couple, with the couple weighing in on whether the findings seem to reflect their experience and understanding of themselves. The couple's preferences for a particular approach to treatment are also incorporated, and therapist and couple work together to evaluate, intervention by intervention, and week to week, what is working and what is not. Therapy shifts to other approaches when lack of progress is due not simply to lack of sufficient effort or practice in new ideas and skills, but rather when progress is made but is insufficient. This constitutes an "idiothetic" approach to assessment and treatment that draws on general findings and theoretical perspectives but always in light of the fit with the unique couple (Fraenkel, 1995).

Framed another way, the therapist's commitment to a particular way of viewing and intervening with a couple needs to be paired with healthy tentativeness, based on the reality that not all theories are sufficient, and not all interventions are effective for every couple. Allegiance to a particular model has been shown to affect outcomes (Blow, Sprenkle, & Davis, 2007). The TP therapist has multiple theoretical allegiances but also reserves a degree of doubt that any one approach will effect all the needed changes. As May writes about commitment to any creative endeavor, "Commitment is healthiest when it is not *without* doubt, but *in spite of* doubt" (May, 1975, p. 21, original emphasis). Decisions about which model to enthusiastically apply at which point depends on session-by-session empirical evaluation of the couple's progress rather than ideological adherence to one approach.

In most cases, couples require the therapist to be more directive initially because they are in a crisis or do not have the skills needed to resolve their problems or reduce their conflict (see the same point in Snyder & Mitchell, 2008; see Chapter 14, in this volume, by Breunlin et al.). It is critical to create a sense of relative emotional safety immediately, especially when at least one partner has been reluctant to come to therapy, often because they feared they would be attacked by the other or criticized by the therapist. The therapist needs to monitor the intensity of affective displays and intervene quickly—usually after no longer than 3 minutes—to interrupt hurtful interchanges. In such moments, the partners are asked to direct their statements to the therapist, with the other asked to listen, knowing that they will have their turn. The therapist looks for often-unrecognized areas of agreement, noting areas of difference as well. The therapist should also suggest in such moments that one early focus of the work might be to teach the couple some structured communication skills with much supporting research. Often, this is already the stated plan, developed after the phone consultation in which the couple described difficulties in communicating as a core problem.

---

[1] This important fact about cat behavior was provided by a well-known senior colleague, Evan Imber-Black, who is also an experienced cat owner.

Sessions typically begin with each partner speaking to the therapist about how they experienced the period since the last session—reporting on progress or the lack thereof around activities suggested, exploring reasons for not engaging in activities, reporting on new challenges, and deciding together on the goals for the current session. At some point in each session, the therapist asks partners to talk with each other about the issue at hand, with guidance from the therapist (or through use of structured communication skills taught in early sessions) to create a positive new experience or enactment (Minuchin, Reiter, & Borda, 2014).

The TP therapist uses self-disclosure selectively, and mostly in moments when the sharing of normalizing psychoeducational information about the couple's problems does not relieve their sense of uniqueness and shame about their perceived failures. For instance, when partners do not seem comforted to hear that many couples in the transition to parenthood experience a sense of disconnection, or are not reassured when told that a large literature documents the challenges of balancing work and family life that they are experiencing, or that, over time, a feeling of boredom about their usual leisure activities occurs for many couples, the therapist might share that these normal challenges and feelings have been experienced personally and various steps have been taken to correct the conditions that led to them. Couples invariably express gratitude for these small self-disclosures.

A different form of self-revelation is more central to TP—that of the therapist drawing on passions and interests outside of the psychotherapy literature to add an element of creativity and personalization to the therapeutic endeavor. The therapist with a background in sports might occasionally utilize sports metaphors to make points about more or less successful forms of relationships (how to become more of a team player, how to value the different contributions of players in different positions to the overall goals), whereas a therapist with a background in music or another art, or in literature, might draw on these sources for metaphors or as actual stimuli to enhance the transportability of interventions otherwise delivered in plain, and somewhat boring, "psycho-prose" (Fraenkel, 2020).

Along the lines of the structural family therapy craft principle of "building intensity" (Minuchin et al., 2014), it is suggested that a key aspect of promoting change is that of *capturing clients' imaginations*. Drawing on metaphors and imagery helps the science of problems and interventions come alive and provides for the clients an experience of connecting with the person of the therapist, but without burdening them with too much self-disclosure about the therapist's own life. Linguists Lakoff and Lawrence (1980) have demonstrated that much of human experience is encapsulated, expressed, and embodied through metaphor; therefore, metaphors can serve as powerful aspects of intervention, especially when based on the meaning system of the couple. However, couples are usually interested in how the therapist sees them and sharing a metaphor from the therapist's own meaning system and interests can be fruitful as well. Although therapy should be based as much as possible on science, Doherty (2012) argues that many of the microdecisions necessary in effective couple therapy are based on the accumulated wisdom of therapeutic craft: "What words at what time and with what tone and body language?" (p. 24). Building intensity through use of metaphor and analogy is one such craft principle (Fraenkel, 2020).

Relatedly, forming and maintaining a strong therapeutic alliance is at the core of TP. Emerging research indicates that strong alliances or working relationships—between the therapist and each partner, between the therapist and the couple as a unit, and between the partners—must be developed early on and are significantly predictive of better outcomes in couple therapy (Knobloch-Fedders, Pinsof, & Mann, 2007). As noted earlier, TP enhances the alliance and credibility of the therapy by offering the couple a wide range of therapeutic resources, both through flexibly shifting the approach based on the couple's stated preferences or their evaluation of the usefulness or lack thereof of the methods offered so far and through attending to subtle openings or affordances communicated through the partners' use of language and their behavior. Whereas a "pure form"/single-theory approach might at times result in a rupture of the alliance if the couple does not prefer that approach, TP can absorb those dissatisfactions and avoid or quickly repair the emerging rupture by responding to clients' preferences for a different set of ideas and techniques. Paired with a warm, genuine, respectful, caring, and unpretentious therapist demeanor, TP communicates a deep dedication on the part of the therapist to offer the couple an effective and even enjoyable experience.

Assessment and Treatment Planning

In TP, assessment is ongoing and intertwined with treatment. As couples engage in conversations and activities designed to assist them, their difficulties engaging in those therapeutic activities reveal organically issues not yet named. For instance, when one partner balks at engaging in an activity such as sensate focus—in which each partner takes turns giving a sensual but not sexual massage to the other, with feedback from the "receiver" as to what feels good and what does not—this reluctance may lead to the partner revealing for the first time a history of childhood sexual trauma. As Doherty (1995) writes, "In the complex mosaic of explanations for human problems, there are plenty of issues therapists can choose to emphasize at different points in therapy" (p. 86).

As noted in the section on healthy versus distressed relationships, a multiperspectival approach by definition includes a wide variety of complementary theories about the sources of couple problems and potential foci for intervention, including present patterns of dysfunctional interaction, thinking, emotions, and physiological arousal; family-of-origin-based sources of reactivity, problematic beliefs, and lacunae in skills and attitudes about how to engage in an intimate relationship; individual psychological challenges in managing temperament, trauma histories, psychological functioning (including diagnosable disorders that may have a biological component), and overuse of substances; as well as stress due to oppressive experiences based on intersectional social locations. Issues of value and safety violations—affairs, violence, gambling, and others—are usually reported as part of the presenting problem in the initial phone call, but they may emerge later, either in conjoint or individual sessions.

The psychological and relational strengths of each partner are partially assessed through a series of questions in the first session, prior to discussing the couple's presenting problem (unless the partners are in such a state of crisis that they find this exploration of strengths annoying). Both partners are asked what they do during the day (work, child care, and if child care, what education and work experience they had prior to becoming a full-time parent); what led them to that work; and what skills, sensitivities, talents, and interests contribute to their doing this work when they are at their best. Couples respond well to these "preproblem" questions, affording them an opportunity to tell the therapist what they are good at prior to describing what they have struggled with in the relationship. The questions also often reveal areas of common psychological and other abilities between the partners on which the therapist can comment and provides an opportunity for the therapist to observe how each partner responds while listening to the other describe their daily activities—with pride and admiration, or with disdain, resentment, or disinterest.

The therapist assesses the strengths and shortcomings of the couple in a first session by asking about how they have attempted to address their issues thus far, and by asking how they met, and what attracted each partner to the other. In line with the findings of Buehlman and colleagues (1992) on couples' oral histories, when partners in a distressed relationship tell a story of initial passionate connection and mutual admiration that sadly got lost over time, this is a strong prognostic indicator of potential to help the couple recover and expand on their initial bond. In contrast, when the couple describes a lack of strong attraction, early serious conflicts, or even worse, a story of almost accidental or pragmatic pairing ("Everyone else was getting married, so we figured we should, too"), the therapeutic road ahead will likely be challenging.

Importantly, it is neither necessary nor even possible to conduct an initial multisession evaluation prior to engaging in interventions. Couples want to get started on change in the first session, and if in crisis, they will not have the patience or wherewithal to explore slowly all their contributing issues. This is particularly true for "last chance" couples, in which one or both partners state that they have committed only to one session to see if it can be helpful (Fraenkel, 2019). The TP therapist assesses only what is necessary at the moment to offer a useful, albeit partial intervention, and learns more about the couple as conflict recedes and they become more comfortable disclosing other themes, which leads to a different set of interventions.

TP does not utilize research-based assessment instruments. Negative early experiences attempting to use such instruments, in which couples felt they were being "studied" rather than met on their own terms through an in-depth trialogue, led me not to pursue use of these structured assessment tools.

Goal Setting

The therapeutic goals generally follow the framework proposed by prevention science: decreasing risk factors and increasing protective factors (Fraenkel & Markman, 2002). Reducing risk factors and building protective factors in the couple's current interactions, beliefs, and emotional reactions usually includes helping partners come to terms with problematic models and experiences from their respective families of origin and bifurcating the past from the present by engaging in novel behaviors that help them differentiate themselves from that past.

The goals of the therapy are set through conversation between therapist and couple, with not only their needs and preferences privileged but also suggestions from the therapist based on observing them and hearing their "story," and how those observed interactions and stories may reflect problematic patterns identified by research. The sequence of which issues to address first and next is created by consensus through these collaborative conversations. When partners differ as to the priority of issues, the therapist attends to the partner who seems most distressed and generally suggests starting with the issue that partner raised. Given that different issues are often linked, the therapist indicates how first addressing this pressing issue will likely help in addressing the other partner's concerns. Attending first to the most distressed partner is often necessary to maintain the alliance with that partner to keep them engaged. In some instances, the therapist may believe that a certain focus should be taken first (e.g., on communication skills) but the couple prefers a different focus (discussing in more depth their painful experiences). The central goal of forming a strong alliance suggests that the therapist should "meet them where they are" and "take them where they were not initially ready to go" later in the therapy.

I have written extensively about how to work with "mixed-agenda" couples (Doherty & Harris, 2017) and other "last chance" couples in which both partners are strongly considering divorce or the nonmarried equivalent (Fraenkel, 2019). Briefly, core practices in working with these couples include validating the ambivalent partner's concerns about the future of the relationship; creating a nonbinding, session-to-session contract in which both outcomes (staying together or separating) are possible, and in which improvement does not preclude eventual separation, yet suspending discussion and steps toward divorce for a short period of time, so as to allow the partners to "experiment with possibility" by trying to improve the relationship and to evaluate the new "data" in terms of decisions about the future of the relationship.

Process and Technical Aspects of Couple Therapy

The overall process of therapy is explained to couples as being a sort of single-case experiment, in which the therapist draws on ideas and techniques from a range of approaches to suggest they try, and that together, therapist and couple will examine the effects of these "experiments in possibility," revise them as needed, or abandon them and try something else. This description of the therapy process strengthens the working relationship, and in the language of psychoanalytic psychotherapy, creates a joint "observing ego" that becomes a model for how the couple can work together as a "We" to solve their problems long after therapy ends.

In a first session, once agreement is established about which problems to address first, and prior to providing the first set of activities to try, the therapist describes a perspective on the change process that couples find validating of their concerns. The principles of this "Creative Relational Movement" approach, which was developed especially for "last chance couples," in which one or both partners report low or no motivation to engage in change efforts, are briefly as follows (Fraenkel, 2019):

1. *Insight does not automatically lead to new action*. In fact, trying a new form of interaction may lead to greater change in thoughts and feelings, as well as new insights or understandings, than will extensive exploration of the painful past. New, preferred actions provide a metaphorical "platform" from which the couple can look down at their troubled past together and understand more clearly how the problems developed. New actions "bifurcate" time more clearly into "the past" and the more hopeful "present-toward-the-future."

2. *Sustained motivation is not necessary for change.* Couples are asked if they have consistently high motivation in other areas of their lives—work, exercise, dieting, practicing an instrument, parenting, and so on. Inevitably, the answer is "no," and the therapist points out that motivation typically increases once we engage in the activity and it becomes self-reinforcing. The key is to try it out and see what transpires.

3. *Change feels initially artificial and irrational.* Any new behavior will at first feel awkward and not spontaneous. The sense of awkwardness is a sign that the couple is doing something new. Although it may seem irrational to initiate small moments of pleasure, appreciation, and affection given how much pain the partners have experienced with one another, couples must act despite this feeling, and see if the experiments lead to more authentic positive feelings and motivation.

4. *Creative experiments with possibility must be "nonbinding."* Even if these lead to positive change, a partner who has considered leaving the relationship might still decide to do so. This is a critical idea for such partners, who may be reluctant to engage in improvement-oriented activities lest these eliminate their rationale for ending the relationship.

5. *Change efforts need to be linked to daily and weekly temporal rhythms.* The notion of establishing "rhythms of relationship" for communication, sex, and other forms of intimacy is generally more palatable to persons than the notion of "scheduling" sex or other activities. Yet without regularizing such activities, and instead, relying on the "myth of spontaneity"—that partners will somehow decide at just the same time that they are ready for sex, problem communication, or other activities, despite their already busy schedules—couples will discover that these activities will likely not take place (Fraenkel, 2011). Creating regular rhythms of activities disrupts the typical pattern of one partner monitoring whether the couple has engaged in such activities or not and approaching the other often in a blaming fashion, leading to conflict that degrades the quality of the time they spend together, often leading again to avoidance.

6. *Change does not occur in the form of linear, steady progress.* Rather, change occurs in an oscillating manner, or "two steps forward, one step (and sometimes two or three steps) back." It is best to wait to introduce this principle until the therapy process stagnates or things decline a bit, rather than at the outset of therapy, when stating this principle might discourage the couple and interfere with their sense of renewed hope in starting to work with a new therapist. Steps back can occur for many reasons, including not consistently putting new skills and attitudes into practice, facing new challenges that the couple is not yet prepared to handle, or because improved communication has led partners to reveal previously undisclosed troubling feelings, often about loss of genuine affection and pleasure with the partner. As has been noted, these moments often signal to the therapist the need to shift the theory and techniques used within the overall integrative framework.

This model of change emphasizes the need for creativity, defined as "the ability to transcend traditional ideas, rules, patterns, relationships, or the like, and to create meaningful new ideas, forms, methods, interpretations, etc.; originality, progressiveness, or imagination" (Dictionary.com, 2019). Existentialist psychologist Rollo May (1975) writes that creativity is "the process of *bringing something new into being*" (p. 39, original emphasis), and notes that courage is "essential for the creative act" (p. 8). He describes courage as "the capacity to move ahead *in spite of despair*" (p. 12, original emphasis). Partners trapped in their negative views of one another and the relationship's possibilities require courage to try new, preferred ways of being and new forms of relational movement, and the therapist is there to support and encourage their acts of creative courage.

In the first session, and with input from the initial phone call, the choice of the focal theory and associated techniques, as well as the degree of directiveness to be taken by the therapist, is made collaboratively with the couple, and is based on several factors:

1. Is the couple in crisis, and if so, what is the nature of the crisis? Couples in crisis require a present-oriented focus and higher level of directiveness—with change efforts directed at maladaptive interactions, negative cognitions, and negative emotions. This usually involves a combination of action-based interventions drawn from CBCT, psychoeducation, mindfulness techniques for addressing dysregulation, and feminist-informed structural family therapy techniques designed to address problematic power differences. Those in crisis about their future (e.g., "last chance" couples) also need a focus on making changes initially in the present, as these changes will help them decide about the future of the relationship.

2. If the couple is not in crisis, and partners communicate without high conflict, the therapist can be less directive and more exploratory, and may utilize a combination of narrative, intergenerational, and psychodynamic approaches to examine the long-standing issues that have led to dissatisfaction and disengagement over time. The time frame focus is more on the past, and on how the past has affected their relationship in the present. However, with such couples, the TP therapist also offers suggestions about activities the couple can do to increase pleasure, connection, and an emerging preferred narrative while they work to understand and come to terms with their painful history.

In all cases, the therapist is attentive to each partner's social locations of race, ethnicity, class, sexual orientation, and so on, and at some point, often in a first session, asks how inhabiting these locations may influence each partner's experience of the presenting problem. For instance, in work with a heterosexual African American couple who had lost their sexual connection, the woman had developed an interest in exploring a wider range of sexual experiences, possibly including polyamory, and said that this grew partly out of her wish to distance herself from her restrictive African American Christian upbringing. The man, who was raised in a similarly religious, socially conservative, low-income family, had been the only one of several brothers to go to college and had a stable, midlevel government job. His focus was primarily on being a hardworking, responsible man, unlike how he experienced his father, and to distinguish himself from racist stereotypes about Black men. Although, in principle, he was willing to explore novel sexuality with his wife, he had difficulty relaxing enough to engage in her fantasies. The couple had two young children and were on the verge of buying their first home.

After the White male therapist demonstrated his respectful curiosity and attempted to understand their cultural backgrounds and racial/ethnic-group-based stressors, one useful intervention with this couple was simply to reframe sex as not another chore that the husband had to accomplish, but as a "play space" in which to experiment, without worrying about the results. The couple found this reframe quite freeing and noted how they appreciated that the therapist had directly asked them how they were experiencing their sexual difficulties as an African American man and woman. As a general principle, when working with couples in which one or more partners inhabits a cultural background or social location different from that of the therapist, the therapist should integrate fluidly questions about cultural beliefs and practices, and the impact of social locations into the process of getting to know the couple, adopting a stance of cultural sensitivity and curiosity (Hardy & Bobes, 2016) rather than attempting to attain a static state of "cultural competence."

Therapy sessions are structured, starting with reports about which actions (including discussions) suggested in prior sessions the couple engaged in and the emotional and cognitive effects of these actions, and if the couple did not engage in those actions, what led them not to do so. The sources of impasse or reluctance are explored and addressed, and the activities are "tweaked" or adapted as necessary for the following week. Reluctance to engage in activities often reveals new themes that need to be explored—ongoing resentments, loss of trust, or low dedication or motivation due to the years of pain. Sometimes, these new themes signal the need to shift to a different theoretical/technical focus—for instance, from CBCT to narrative, family-of-origin, psychodynamic, biobehavioral/neurophysiological, or experiential foci. Whatever the theoretical perspective taken at the moment, the therapist responds with empathy and attempts to understand each partner's struggles with the process of change and elicits their ideas about how to address their issues, all of which strengthens the alliance.

The practice of being "multipartial"—empathic with both partners, especially when they have quite different experiences and perspectives—and proposing a systemic "metaposition" that incorporates both partners' feelings and thoughts as reflecting their problematic polarization, are central activities of many sessions. A useful reframe about inevitable differences is that couples have "binocular vision"—just as the two eyes register different retinal images of an object and these images create depth perception, so, too, can partners' differences provide useful "depth perception" about the challenges they face if they "harness" those differences rather than attempt to eliminate them. A useful humorous comment often helps as well: for example, "If you want to divorce and marry a *mirror*, Target's got a great sale on right now, $19.99 plus tax for a full-length mirror, and then you can talk to yourself!"

Major techniques used in TP are mostly based on findings on what distinguishes happy from unhappy couples. TP focuses on the basic systemic goal of introducing novelty (Minuchin et al., 2014)—new emotions, new thoughts, and new interactional behaviors, all within a therapeutic relationship of care and compassion. Structured communication and problem-solving techniques drawn from CBCT form the skills-building backbone of the approach (see Chapter 3 on CBCT, in this volume, by Baucom et al.), with the added emotionally focused technique of encouraging "softening" or sharing of vulnerable emotions (see Chapter 6 on EFT, also in this volume, by Johnson, Wiebe, & Allan) when this does not occur spontaneously. Mindfulness-based practices to assist partners with self-regulation are introduced as part of the communication skills. These skills are also promoted as a core means of repair after relational ruptures.

Improvement in communication plays a central role in all approaches to couple therapy. From TP's multiperspectival approach, teaching CBCT-based communication skills can be viewed as simultaneously facilitating therapeutic goals viewed as important from different theoretical vantage points. These include creating positive enactments (structural couple therapy) as a means of differentiating from the problematic maps of conflict experienced in families of origin (intergenerational therapy); as a tool to override intrapsychically based fears about speaking one's mind, creating a means to decrease projective identification of emotions, and creating opportunities for corrective emotional/relational experiences (psychodynamic couple therapy); as strengthening attachment security through being heard and understood (psychodynamic and emotionally focused therapies); as equalizing power and voice between partners (feminist and queer couple therapy); as helping to build a new, preferred story of competence and care (narrative therapy); and as a means to actualize a future without high conflict, a goal that often emerges when having couples answer the Miracle Question (solution-focused therapy).

In each session, at some point the therapist guides the couple to engage in an enactment—talking to one another in a new, more vulnerable manner, engaging in a creative ritual of putting aside their painful history, expressing affection at a moment when physical touch would further express verbalized feelings, among others, created in the moment based on the couple's particular issues.

Besides practicing communication and problem-solving skills and reserving 1 hour a week for such discussions ("relationship care and maintenance"), other frequently suggested between-session activities include responding to partner's bids for attention, daily statements of appreciation and admiration; being more open to taking influence from one's partner; holding nightly "decompression rituals" including a "How was your day, dear?" conversation (Fraenkel, 1998a); doing six daily "60-second pleasure points"—a minute or less of fun, pleasure, or sensuality, with each partner initiating three across the day (Fraenkel, 1998b); taking a silent walk and pointing to interesting sights; sensate focus; and other activities created especially for the particular couple. The key is not to focus solely on risk prevention and problem-solving activities, or to work on these skills for weeks before introducing ideas and practices to enhance mutual enjoyment, but to include as soon as possible activities that promote pleasure, passion, friendship, and intimacy. Couples are less likely to persist in therapy if it is solely centered on solving problems; after all, they did not become partners solely for this purpose, but rather, to experience joy and passion as well. Weaving together risk prevention and pleasure enhancement also communicates an important point: Relationships inevitably experience conflicts and problems, and it is possible and crucial to continue to create enjoyment even while dealing with difficulties.

MECHANISMS OF CHANGE

As a multiperspectival approach, TP holds that there are several mechanisms of change. At the broadest level, change occurs through new learning that with practice becomes new patterns, and this learning and pattern building occurs within a compassionate, creative therapeutic relationship that stimulates a more compassionate, creative relationship between the partners.

The Role of the Therapeutic Alliance in Promoting Change

Put plainly, the couple must experience the therapist as genuinely caring about them—as individuals as well as a couple—and as dedicated to helping them relieve their suffering. Caring about the couple does not mean being determined to preserve their relationship. Especially when working with "last chance couples" on the brink of divorce, therapists must describe their bias toward helping partners stay together, but state that they will help them decide whether to stay together or end the relationship and should invite partners to comment if they feel the therapist is unwittingly pushing them in either direction (Fraenkel, 2019).

The emotional connection in the therapeutic alliance creates trust in the therapist and openness to ideas and suggestions. From a psychodynamic/family-origin perspective, the therapist's engaged and soothing presence can provide a corrective relational/emotional experience for persons who experienced critical or neglectful parenting and can allow persons to "internalize" the therapist, promoting greater self-soothing abilities. The therapist's caring behavior around the couple's problems and repeated synthesizing of partners' different perspectives into a coherent "both–and" couple-level perspective also models for the couple acts of compassionate listening and blending their different points of view into a perspective on themselves that includes both partners' needs and understandings.

Similarly, when the therapist explores one partner's family- and culture-of-origin experiences in the presence of the other partner and develops an "honorable" psychosocial explanation for the behaviors and emotional reactions that annoy the listening partner, it is not just the *content* of those insights that represents transformative learning—it is also about learning a model of searching for compassionate reasons for one's partner's behavior. Furthermore, as one partner's historical sources of sensitivity and relational beliefs are gently explored by the therapist, this often stimulates the other partner to reflect on their own histories and the impact of those experiences on the current relationship, thereby representing an example of vicarious learning. This theory of change aligns with the psychodynamic–systemic theory of reflective functioning and mentalization in which a couple's intimacy develops in part through a process of getting to know one another's minds.

Put in technical terms, the positive therapeutic alliance—particularly the quality of the emotional bond between the therapist and each partner, and the relationship as a whole—is the necessary but not sufficient condition for the partners to take influence from the therapist (a process called "joining" in structural family therapy), whether that influence is regarding suggestions for new forms of interaction, questions that draw out unspoken emotions and thoughts, or observations made by the therapist about each partner's contribution to their patterns. As the central common factor of therapy, the alliance provides the supportive relational context within which specific techniques drawn from a wide variety of models gain their effectiveness (see Chapter 13 on common factors, in this volume, by Davis).

Promoting New Learning

The mechanisms of change can be grouped under the broad categories of new learning through new *interaction*, and new learning through shifts in *awareness and understanding* represented by changes in cognitions/perceptions, emotions, and physiological responses. These mechanisms of change are interrelated in that change in one area can stimulate change in another. Clinical experience with couples suggests that change in observable action/interaction often must precede changes in cognitions/perceptions, emotions, and physiology. Observable changes in action—accompanied by verbal and nonverbal signals that the partners are sincere in their attempts—are needed to provide data that contradict the well-practiced negative assumptions and attributions each partner holds about the other and the relationship's potential (Bradbury, Fincham, & Beach, 2000). Drawing on the phenomenological philosopher Heidegger (1962), whose work influenced the development of existential–humanistic therapies (Schneider & Krug, 2017), in order to expand one's experience of *Dasein* or "Being-in-the-World," it is necessary to engage in activities that escape one's accumulated expectations about what is possible through entering what he called *und Lichtung* or a "clearing." Metaphorically speaking, partners' existing beliefs and attributions about the other are like a forest of trees that block out the sun. Entering a "clearing" by engaging in irrational-seeming, novel interactions allows for surprises that violate those assumptions and revise partners' beliefs about what is possible, and thereby changes their feelings about one another and the relationship.

One of the major challenges in doing couple therapy is getting couples to try new things, and to continue to practice them, so that they yield the desired "self-reinforcing" effects and become automatic patterns that replace previous undesirable patterns. TP utilizes three major techniques to encourage couples to try new things. First, sharing the principles of the "creative relational movement approach" described earlier helps to anticipate couples' usual experiences that trying new things feels awkward and irrational, and that they do not feel authentically motivated to try them. The TP therapist can also note that "marriage is largely a motor skill," and with practice, the new patterns will become automatic, but the partners need to put some admittedly awkward-feeling effort into establishing these patterns, just as they would in learning a new way to swing a tennis racket, play a new figure on an instrument, or use a new piece of technology or software.

Second, by introducing the new activities when couples demonstrate some openness to them (looking for "affordances"), the activities have a greater chance of being implemented. For instance, with one couple in which the husband had frequently been intimidating to the wife, he was ready to end therapy prematurely once the couple learned communication skills. The therapist had noticed that the husband spoke of how, when the partners are apart, "demons appear, leading us to take each other's negative inventories." Based on this metaphor, the therapist guessed that he might be open to the narrative therapy practice of externalizing, which successfully helped him externalize shame (which he called "The Dark Knight: V") that often led him to become intimidating to his wife.

Third, the therapist utilizes the craft principle described earlier from SFT of "building intensity." One intensity-building method already described is to creatively use humor, imagery, music, and other sources of meaning making to translate science-based interventions such as "responding to your partner's bids for attention" and "making statements of admiration and appreciation" into memorable, personalized activities (as was illustrated in the example of the husband showing adoration to the wife by treating her like a cat). Another method of building intensity is to dramatically (but with a smile) state that the couple who has just learned new communication skills or some other research-supported activity now has a choice: They can use these techniques and improve the relationship, or they can return to their previous problematic ways of interacting. For instance, the therapist can say, "You are officially certified by (name of therapist) to use the speaker–listener technique. You now have my seal of approval. You can leave this office and never again engage in the destructive patterns that brought you here, or you can decide to go on using those destructive patterns—it's your choice." If the couple notes that they have difficulty utilizing the technique when upset, the therapist can remind them about using mindfulness techniques to calm their nervous systems, and also quote existentialist psychologist Rollo May (1975): "Human freedom involves our capacity to pause between stimulus and response and, in that pause, to choose the one response toward which we wish to throw our weight" (p. 100).

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

In its flexible use of a wide variety of theories and techniques, TP is designed to be effective for any couple, from nondistressed couples looking for distress/divorce prevention relationship education to highly distressed "last chance" couples. This multiperspectival stance means that couples do not need to be referred to another therapist when their needs shift: Rather, the TP therapist shifts approaches to match the needs of the couple. As noted earlier, some couples come with one or both partners already in individual therapy or are being treated with psychotropic medications. Referrals are made if adjunct treatments seem necessary but, given that research supports the impact of couple therapy on a variety of individual psychological problems, the impact of couple therapy on these symptoms is first assessed prior to making referrals for other treatments.

TP has not been tested empirically. However, it draws on theories and techniques that have amassed a good deal of empirical support, and interventions are targeted largely on variables found to distinguish distressed from happy couples. TP can therefore be viewed as "empirically informed" (Sexton et al., 2011).

CASE ILLUSTRATION

The following case (with identifying information disguised) was a "last-chance couple": one of those in which at least one partner has lost a sense of passion and love for the other, and the couple is disconnected. The couple also is an example in which at least one partner has violated the values of commitment and trust. The case illustrates the TP approach of moving fluidly between a present-to-future-oriented time frame and a past-to-present (family-of-origin and culture-of-origin) time frame; moving among the four change entry points of interaction, cognitions, emotions, and physiology; the initial privileging of action-oriented techniques followed by more attention to understanding/insight and back to action; as well as the need to be more directive initially with a couple in crisis, followed by a less directive approach after the couple gains a sense of relational competence and a sense that the therapy can offer them concrete tools for change.

Stanley, 33, and Lily, 31, were both second-generation Chinese Americans (meaning, the first generation to be born in the United States) raised in the New York City area. Stanley's parents had moved from Hong Kong with little money and worked hard in the restaurant business, and having had success, opened a real estate business as well. He was raised initially lower-middle class but by the time he was a teenager, the family was solidly middle class, and lived in a middle-class neighborhood in Queens. Lily's parents, also from Hong Kong, were more financially secure when they moved to the United States, having made substantial money in the clothing retail business, which they continued in New York, and she was raised at the high end of upper-middle class in a suburb. Lily and Stanley were both physicians and met in medical school. Stanley worked in emergency medicine, and Lily was a pulmonologist.

Stanley made the initial call, having been referred by a former client of the therapist. Together 7 years and married for 5, the couple had recently ended a short first try at couple therapy because they felt that "the therapist seemed to be trying to fit us into her curriculum" and they felt the therapist was not attending to their "particular story" and the crisis they faced about whether to remain married. Stanley (and later Lily) said that the therapist did not seem to acknowledge Stanley's ambivalence about whether to stay married, and he felt pressured by the therapist's assumption that the therapy would convince him to stay.

In both the initial call and in the first session, Stanley related that he was quite unhappy and that the "relationship feels lopsided," as he did most of the household maintenance, cooking, financial management, and organizing of the couple's social activities. Four weeks earlier, he told Lily that he was considering divorce. Lily was shocked and said that she had no idea he had been so unhappy for so long. Stanley reported that he had tried to tell her many times, maybe not forcefully, but "You would blow me off, saying it wasn't the right time to talk." Lily countered that she could understand his frustration but not that it would lead him to want to divorce. Stanley explained that, over time, he felt they were essentially living separate lives, and that he was not feeling the same love he once felt for her. Hearing how Stanley felt greatly upset Lily, and she felt determined to rectify her part of the disconnect between them.

When the two had first met, they fell quickly and passionately in love, and the first 2 years they traveled when on break from medical school, dined out frequently, and socialized with friends. Stanley was 2 years ahead of Lily in med school, and when he started his residency, they found themselves often with little time together, and with their daily schedules out of sync. Stanley often worked for 2 days straight and would come home in the morning just as Lily was going off to school. Their daily schedules became even more different once Lily started her residency, and weekends for both were often spent at the hospital. In addition, as an emergency room (ER) doctor, he typically worked several days and nights in a row, then had a few days off, and spent many free evenings with friends when Lily was busy at the hospital. Stanley had finished residency training 2 years earlier, giving him a slightly less demanding schedule, whereas Lily had just become an attending physician and still had a highly demanding routine.

Stanley reported that over the last 3 years, he had tried to tell Lily that he was unhappy. Lily agreed "100%" that Stanley was almost entirely managing their lives, and since Stanley raised the possibility of divorce, she had started sharing more of the cooking and cleaning. Describing the evolution of the classic circular overfunctioning–underfunctioning pattern, Lily said, "It's not that I couldn't do these things, but it's like, the more he did, the less it seemed there was for me to do, so I just didn't think about it. In retrospect, of course I understand your (Stanley's) resentment that I wasn't doing much. Now I've woken up!" Asked about their experiences doing chores growing up, Lily smiled in an embarrassed way, and said, "Well, that's probably one reason I didn't see it—my parents had household help, and they expected me just to focus on school! I never did any chores." In contrast, although Stanley's parents were equally intent that he perform well academically, they required Stanley and his brother to do chores, including cooking, as both parents worked long hours. The couple acknowledged that although they shared a cultural background, they differed in terms of the social classes in which they had been raised.

Adding to the couple's distress over the past weeks was that Stanley had just told Lily that he had flirted some with a nurse at the hospital and talked with the woman about his marital problems. Nothing physical had occurred, but Lily was devastated by this news. She told her parents and brother, and they were outraged, suggesting this revealed a character flaw in Stanley. Stanley had told his brother about the couple's problems, asking him not to reveal these to their parents, but the brother did, and his family had the opposite advice for Stanley—do not divorce, work it out. Unfortunately, this pressure from his parents made him *more* inclined to pursue divorce, as he fashioned himself as independent-minded.

Although most "last chance" couples often present with some degree of emotional urgency, the pressure to figure out their future—and on the therapist to help them—was amplified by Lily's need to decide whether to pursue a 3-year fellowship, a decision she needed to make in the next 2 weeks. Stanley was supportive of Lily's career goals but acknowledged that the fellowship might take her to another city, further impeding their ability to restore their relationship. Given this time pressure, the couple asked to be seen twice a week for the following 2 weeks.

The therapist shared the following impressions with the couple, and outlined a plan to work with them, pending their approval. First, he noted that his approach to working with couples in which one or both partners are considering divorce is to suggest they engage for a short period of time in "experiments in possibility" to see if new skills and other activities might lead to improvement, providing them more "data" with which to make their important decision. He noted that although he would work enthusiastically to explore their capacity for change, he did not want his enthusiasm to lead either of them, especially Stanley, who had raised the possibility of divorce, to feel pressured to stay together. Stanley said he was relieved to hear this, as it differed from the approach of the previous therapist, and from the urgings of his family.

The therapist noted that due to their intense academic demands and work schedules as doctors-in-training, their daily and weekly rhythms had resulted in them leading largely separate lives, with little time for intimacy. Unfortunately, they had hoped they would survive this period intact (Stanley had "rung the alarm bell" a few times, although perhaps not loudly enough to get Lily's attention), and they had not engaged in intentional strategies to stay connected. To bolster the credibility of this perspective, the therapist noted his prior experience working with physician couples struggling with the same issue, and his clinical/theoretical work on the importance of addressing the effects of temporal dyssynchronies on relationships. He noted that to best evaluate the potential for their relationship, it would be important to work on resolving their conflicts and at the same time, experiment with increasing pleasure that might also restore mutual affection. He suggested offering them some techniques for making the most of small amounts of connection even while apart, such as the 60-second pleasure-point activity, and "microplanning" each week to make sure they had some time together. Based on empirical findings about predictors of relationship satisfaction over time, he also suggested that they each make one statement of appreciation or admiration each day, and to connect with their professional identities, called this a " 'One a Day' relational vitamin," which made them laugh.

The therapist noted that although they said they were not "a screamer couple," he wondered if each partner had some reluctance to discuss emotional upset with the other, perhaps for fear that it would lead to intense conflict. Both partners agreed that they were conflict-avoidant. The therapist asked what they had each observed in their families of origin in terms of their parents' expressing emotions and handling conflict. Both smiled and related that in traditional Chinese culture, one was not encouraged to express either positive or negative feelings, and neither had witnessed their own parents productively discussing problems—Stanley's parents would occasionally erupt in anger at one another but never seemed to solve their issues, whereas Lily had never seen her parents talk about their relationship, even though her mother had long confided in her that she was unhappy with her father. The therapist suggested he could offer them some research-based, structured communication and problem-solving skills in the next session to help them feel emotionally safer talking about feelings, and both agreed this would be useful.

Stanley added that this conversation about their families and shared culture made him realize that in Chinese culture, one typically shows love by doing "caretaking things," and that part of his diminished love of Lily was probably due to not feeling love from her through such acts. "It's not that I expect a woman to take care of me, not at all—I just expected that we would take care of *each other* and show our love to each other that way." Lily again expressed regret but also said that she had decided to become more emotionally expressive to improve on what she saw with her parents and the broader culture, and she thought Stanley understood "how important words and emotions are to me, both positive and negative." The therapist reiterated that the communication skills would likely help, as they did not have models for how to express themselves openly. The session ended with the therapist noting that the activities he had suggested they try between sessions would likely feel a bit artificial and awkward (one of the principles of the creative relational movement approach to change), especially as they were not sure about the future of the relationship, but he said with a smile and joking tone, "This is my prescription, doctors, just like when you tell patients to change their health habits!", eliciting a laugh and a statement that both were committed to trying them.

In the following session, Stanley and Lily reported that they had done the daily statements of appreciation and admiration and tried the 60-second pleasure-point activity, although when apart and busy with patients, Stanley sometimes forgot to send Lily a text, once again demonstrating to them how challenging their work rhythms were to sustaining efforts to connect. As planned in the previous session, the therapist described the research findings on major problem patterns of communication, and both acknowledged that they tended to withdraw from possible conflict and had each been attributing negative intentions to the other's behavior. The therapist taught them communication skills and a technique for clearly expressing how one feels when one's partner behaves in a particular manner, drawn from CBCT. Lily was excited about the technique for expressing feelings, reiterating that she rarely heard Stanley directly express his emotions, which Stanley acknowledged.

The couple decided to discuss tension around Stanley's greater desire to spend time with friends—with Lily when she was available, but without her when she was not—whereas Lily described herself as more of a "homebody" who prefers more time relaxing together. Stanley described feeling resentful when Lily asked him when he would be coming home from gatherings with friends even when she was still at the hospital. The therapist paused the speaker–listener exercise to ask Stanley what led to his feeling of resentment. He said he was not sure, just that he felt Lily was trying to control him. Based on a guess that her request reminded him of a parent telling him to come home, the therapist asked him how his parents related to his socializing in high school. He said his mother would often call him multiple times to ask when he would come home. It had never occurred to him that Lily's request reminded him of his mom. With the couple amazed that he had intuited this connection, the therapist joked that the reason he could do this was that he had a kind of crystal ball that helped him figure things out and showed them his crystal ball from his set of therapeutic props. They laughed. The purpose of this small bit of comedy, which the therapist inserts at times into the therapeutic process, is to create a sense of humor and enjoyment when talking about difficult topics, and also to provide memorable, unexpected moments and images that remind clients of important points addressed in the session.

This issue of how the couple preferred to spend leisure time—at parties with friends versus at home relaxing—led to a broader question posed by the therapist about whether Stanley was drawn more to excitement experiences and affects, whereas Lily preferred more peaceful experiences and quieter arousal states. The couple found this idea accurate and said it explained a lot about their conflicts. Lily noted that Stanley's adventuresomeness was one of the things that initially attracted her to him, as she had led a privileged but sheltered life as a child, and Stanley countered that he found Lily's calmness appealing—but that now they often disagreed about which types of experiences to engage in during their free time.

The therapist wondered if this difference in preference for levels of arousal might also be tied to differences in life pace, with Stanley preferring a fast pace and Lily a slower pace, reflected also in their respective medical specialties, and both said this fit exactly. The therapist explained that couples are often attracted by such differences in emotional style as well as pace, and that these differences sometimes become polarized. He suggested that a goal for them might be to "revalue" the complementary aspect of the differences, but to depolarize them and create a "both–and" in which they find a balance between exciting activities and socializing with friends, and calmer time together. The therapist noted that in some ways the development of their relationship into a "We" had been put on hold due to their medical training, and that they were still often operating more in a "You and Me" style. Finding compromise around how they spent leisure time would be important to establishing more of a sense of the "We."

In a subsequent session, the couple reported that they had made love a few times and that things were generally improving as they experimented with rebuilding and strengthening their "We." Using the structured communication skills format, Lily brought up her lingering upset about Stanley's flirtations with the nurse in the weeks before they started therapy. Even though their relationship was now improving, this raised concerns about Stanley's "character" and whether she could fully trust him. Stanley reiterated that he knew it was wrong, but that he just felt so cut off from Lily that he found himself open to the colleague's advances. He said he did not know what else to say about it. Lily seemed unmoved. Sensing the need to connect with both partners' pain and frame the issue relationally, the therapist empathized with

Lily's sense of betrayal but mentioned that sometimes, a flirtation or full-blown affair is based on the partner having the affair feeling betrayed as well—ignored and not responded to when he or she raises concerns about not getting enough attention from the partner. This made sense to both partners: Stanley reiterated that he felt badly about the flirtation, and Lily softened her attitude about it, although she still seemed reluctant to fully forgive him.

In an individual session, Stanley revealed that even though things were generally improving, he still was not sure he could love Lily as he had before. He shared more openly how hurt he had felt when she had ignored his requests that she get more involved in their shared life and responsibilities—which, he reiterated, was more about feeling uncared about and feeling that she was more like his child than a full partner. He felt he had drifted away and was somewhat doubtful that he could "get the love back." The therapist noted that it might take some time for Stanley to feel fully affectionate toward Lily and to be fully convinced that Lily was committed to changing. The therapist suggested that Stanley bring up these feelings in the next session.

Lily decided to forgo starting her fellowship for the year and focus on strengthening the marriage. She also reflected that this might be a welcome break from her relentless medical training. Over the next few weeks, she and Stanley engaged in more pleasurable activities both as a couple and with friends, and decided to go on a weeklong vacation, their first in several years. On this trip, they encountered a group of young single women, who they both reported were at times flirtatious with Stanley. He described several actions he took to distance himself from them, such as getting out of the pool when they gathered around him when Lily went to get a sandwich, but Lily had assumed he just got tired of being in the pool, and that he was bored being with her (because he looked unhappy), and he felt she did not realize his intentions to "protect the We." Stanley, whose demeanor was typically reserved even when speaking about his emotions, spoke for the first time more expressively, telling Lily, "I'm frustrated that you don't *see me*, and always seem to assume the worst!" Lily acknowledged that she was focusing on every moment when he seemed unhappy but said that he was sometimes hard to read and asked him to tell her more directly what he was doing in moments like these to protect their relationship. In addition, she still had "trust issues" because he had flirted with the nurse. Stanley remained frustrated, again wishing that she could just see what he was doing in a positive light. He also noted with some bitterness that these moments made him feel like she was blaming him for their problems, when he was the one who had suggested couple therapy and had voiced his complaints about her neglecting the relationship. He resented now that he had to make "all these changes." Lily said she understood his feelings but that she needed him to help her "read" him more accurately.

The therapist noted that because of her anxiety that Stanley still was considering divorce, she was extremely focused on any signs that he might be unhappy, suggesting that if Stanley could be a bit more communicative about his feelings at least for a period of time, even though it was not natural for him to do so, it would help Lily "take the magnifying glass" off him and learn to "read" him better and recognize the positive intentions motivating his behaviors to "protect and nurture the 'We.'" Once again, the therapist used a prop—a large magnifying glass—to bring home the point. Lily also mentioned that she had been scouring her memories of the last few years to locate the moment Stanley seemed to change his attitude toward her, in hopes of further explaining how they had gotten to this point. The therapist said to her, with a smile, "With all due respect, doctor, I think we have already ascertained the cause of the condition, and there is no need for further examination!" She laughed and asked, "Really?" The therapist said, "Yes, really!"

In an individual session, Lily cried about how, despite all their progress, Stanley had not yet declared that he was no longer thinking about divorce as a possibility. The therapist reiterated Stanley's feeling that he was now being largely blamed for their difficulties because he had flirted with another woman. The therapist suggested that since she now understood what prompted Stanley to flirt and her role in leading him to feel unappreciated and lonely, she might consider formally forgiving him. The therapist noted that forgiving Stanley did not mean excusing his behavior—it would just mean that she understood it and was willing to drop it and move on. Lily said she thought she could do so. The therapist suggested this be done as a ritual of moving on. Lily said she preferred to do it with the therapist present as a witness and said she would prepare to do it in the next session.

In that following session, both Lily and Stanley reported that things had been much better. They had some other couples over for dinner, and Stanley appreciated that Lily had helped him serve the guests, whereas in the past she would just hang out with them, leaving him to do all the work. The therapist then asked Lily if she was ready to do what was discussed in the individual session, and she read from a card a quite moving statement about being ready to move on from his dalliance with the nurse. She noted with tears that although she did not excuse his behavior, she understood it and her contribution to the feelings that led him to it. Stanley looked deeply moved, and again apologized, and reached out to hug her. The couple hugged for several minutes, speaking quietly and lovingly to one another. From then on, divorce was "off the table," and the couple continued for four more sessions to work on solidifying and affirming their renewed relationship. Among other things, each spoke with their respective families to announce that they would stay together, and Lily convinced her protective parents and brother to accept Stanley back into their family.

CONCLUDING COMMENTS

TP is a comprehensive, flexible, and creative approach designed to work with couples at any level of distress, and with any particular set of challenges. It is comprehensive in that it draws on the major specific models that have accumulated either research support or extensive clinical/anecdotal support. Rather than being a higher-order integration, it is a multiperspectival approach, honoring the rich cornucopia of existing approaches, yet recognizing that each tends to focus on one particular *change entry point* (interactional behavior vs. thoughts/beliefs/narratives vs. emotions), one particular *time frame* (present vs. past vs. future), and one particular stance about *directiveness*. TP allows for flexibly shifting among the different theories and associated practices, even within one session, based on couples' observed and reported needs, and the affordances or openings they present during the therapeutic trialogue. Essentially, TP is a guide to navigating the moment-to-moment choice points that couple therapists face about what might promote change best in a particular moment (Fraenkel, 2009). At the core of the therapeutic process is close attention to developing and maintaining the therapeutic alliance, which includes offering a therapy that seems credible, responsive, and trustworthy. It is believed that this flexible, comprehensive integrative approach promotes the sense of methodological credibility and therapist responsiveness.

Finally, the name of the approach—the therapeutic palette—and the artistic metaphor this name is meant to connote, is meant to emphasize that the therapist must be *creative* in responding to the wide variety of couples encountered, yet it is based as much as possible on the science of couple health and distress. All couples cannot be fit neatly into one specific approach to treatment. They come with their own ideas about what might help them, including those based on cultural backgrounds; prior experiences in couple therapy that did not help them (and which they want to avoid); and even aesthetic sensibilities that may not fit with a particular model of therapy (e.g., some partners being fond of action approaches in their lives, and others finding those "superficial" and preferring "deep reflection" and nuanced discussions of emotions). The TP therapist brings a wealth of research and theory-based knowledge about couple challenges but views each couple as unique and is prepared to co-create a productive, and one hopes, interesting experience in change.

SUGGESTIONS FOR FURTHER STUDY

Fraenkel, P. (2009). The therapeutic palette: A guide to choice points in integrative couple therapy. *Clinical Social Work Journal, 37,* 234–247.

Fraenkel, P. (2018, March). *The last-chance couple: Saving relationships on the eve of destruction* Presentation at the Psychotherapy Networker Symposium, Washington, DC. www.peterfraenkelphd.com.

Fraenkel, P. (2019). Love in action: An integrative approach to last chance couple therapy. *Family Process, 58,* 569–594.

Fraenkel, P. (2020). Integrating music into couple therapy theory and practice. *Clinical Social Work Journal, 48,* 319–333.

Fraenkel, P. (in press). *Last chance couple therapy: Bringing relationships back from the brink*. New York: Norton.

REFERENCES

Aron, A., Norman, C., Aron, E., McKenna, C., & Heyman, R. (2000). Couples' shared participation in novel and arousing activities and experienced relationship quality. *Journal of Personality and Social Psychology, 78,* 273–284.

Benjamin, J. (2017). *Beyond doer and done to: Recognition theory, intersubjectivity and the third.* New York: Routledge.

Benson, L. A., McGinn, M. M., & Christensen, A. (2011). Common principles of couple therapy. *Behavior Therapy, 43,* 25–35.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself?: The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33,* 298–317.

Bodenmann, G., & Randall, A. K. (2020). General and health-related stress and couples' coping. In K. S. Wampler & A. J. Blow (Eds.), *The handbook of systemic family therapy* (Vol. 3, pp. 253–268). London: Wiley.

Boyd-Franklin, N. (2003). *Black families in therapy: Understanding the African American experience* (2nd ed.). New York: Guilford Press.

Bradbury, T. N., & Bodenmann, G. (2020). Interventions for couples. *Annual Review of Clinical Psychology, 16,* 99–123.

Bradbury, T. N., Fincham, F. D., & Beach, S. R. H. (2000). Research on the nature and determinants of marital satisfaction: A decade in review. *Journal of Marriage and the Family, 62,* 964–980.

Braukhaus, C., Hahlweg, K., & Kroeger, C. (2003). The effects of adding booster sessions to a prevention training program for committed couples. *Behavioural and Cognitive Psychotherapy, 31,* 325–336.

Buehlman, K. T., Gottman, J. M., & Fainsilber Katz, L. (1992). How a couple views their past predicts their future: Predicting divorce from an oral history interview. *Journal of Family Psychology, 5,* 295–318.

Constantino, M. J., Coyne, A. E., Boswell, J. F., Iles, B. R., & Visla, A. (2018). A meta-analysis of the association between patients' early perception of treatment credibility and their posttreatment outcomes. *Psychotherapy, 55,* 486–495.

Davis, S. D., Lebow, J. L., & Sprenkle, D. H. (2012). Common factors of change in couple therapy. *Behavior Therapy, 43,* 36–48.

Dictionary.com. (2019). *Definition of creativity.* www.dictionary.com/browse/creativity.

Doherty, W. (2012, September/October). One brick at a time: Therapy is more craft than art or science. *Psychotherapy Networker,* pp. 23–29.

Doherty, W. J. (1995). *Soul searching: Why psychotherapy must promote moral responsibility.* New York: Basic Books.

Doherty, W. J., & Harris, S. M. (2017). *Helping couples on the brink of divorce: Discernment counseling for troubled relationships.* Washington, DC: American Psychological Association.

Falicov, C. (1998). *Latino families in therapy.* New York: Guilford Press.

Fishbane, M. D. (2013). *Loving with the brain in mind: Neurobiology and couple therapy.* New York: Norton.

Fraenkel, P. (1994). Time and rhythm in couples. *Family Process, 33,* 37–51.

Fraenkel, P. (1995). The nomothetic–idiographic debate in family therapy. *Family Process, 34,* 113–121.

Fraenkel, P. (1997). Systems approaches to couple therapy. In W. K. Halford & H. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 379–413). London: Wiley.

Fraenkel, P. (1998a). Time and couples: Part I. The decompression chamber. In T. Nelson & T. Trepper (Eds.), *101 interventions in family therapy* (Vol. 2, pp. 140–144). West Hazleton, PA: Haworth Press.

Fraenkel, P. (1998b). Time and couples: Part II. The sixty second pleasure point. In T. Nelson & T. Trepper (Eds.), *101 interventions in family therapy* (Vol. 2, pp. 145–149). West Hazleton, PA: Haworth Press.

Fraenkel, P. (2001). Getting a kick out of you: The jazz Taoist key to love. In J. Levine & H. Markman (Eds.), *Why do fools fall in love?* (pp. 61–66). San Francisco: Jossey-Bass.

Fraenkel, P. (2009). The therapeutic palette: A guide to choice points in integrative couple therapy. *Clinical Social Work Journal, 37,* 234–247.

Fraenkel, P. (2011). *Sync your relationship, save your marriage: Four steps to getting back on track.* New York: Palgrave-Macmillan.

Fraenkel, P. (2017). Integration in couple and family therapy. In J. Lebow, A. Chambers, & D. Breunlin (Eds.), *Encyclopedia of couple and family therapy* (Vol. 3, pp. 1501–1506). New York: Springer.

Fraenkel, P. (2019). Love in action: An integrative approach to last chance couple therapy. *Family Process, 58,* 569–594.

Fraenkel, P. (2020). Integrating music into couple therapy theory and practice. *Clinical Social Work Journal, 48,* 319–333.

Fraenkel, P., & Capstick, C. (2012). Contemporary two-parent families: Navigating work and family challenges. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (4th ed., pp. 78–101). New York: Guilford Press.

Fraenkel, P., & Markman, H. J. (2002). Prevention of marital disorders. In D. S. Glenwick & L. A. Jason (Eds.), *Innovative strategies for promoting health and mental health across the life span* (pp. 245–271). New York: Springer.

Fraenkel, P., & Pinsof, W. M. (2001). Teaching family therapy-centered integration: Assimilation and beyond. *Journal of Psychotherapy Integration, 11,* 59–85.

Gibson, J. J. (1979). *The ecological approach to visual perception.* Boston: Houghton Mifflin Harcourt.

Good, J. M. M. (2007). The affordances for social psychology of the ecological approach to social knowing. *Theory & Psychology, 17,* 265–295.

Gottman, J. M. (2011). *The science of trust: Emotional attunement for couples.* New York: Norton.

Gurman, A. S. (1981). Integrative marital therapy: Toward the development of an interpersonal approach. In S. H. Budman (Ed.), *Forms of brief therapy* (pp. 415–462). New York: Guilford Press.

Hardy, K. V., & Bobes, T. (2016). *Culturally sensitive supervision and training: Diverse perspectives and practical applications.* New York: Routledge.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family Process, 17,* 181–194.

Heidegger, M. (1962). *Being and time.* New York: Harper & Row.

Jackson, D. (1965). Family rules: Marital quid pro quo. *Archives of General Psychiatry, 12, 585–594.*

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2007). Therapeutic alliance and treatment progress in couple psychotherapy. *Journal of Marital and Family Therapy, 33,* 245–257.

Lakoff, G., & Lawrence, M. (1980). *Metaphors we live by.* Chicago: University of Chicago Press.

Lebow, J. L. (1987). Integrative family therapy: An overview of major issues. *Psychotherapy, 40,* 584–594.

Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process, 36,* 1–17.

Lebow, J. L. (2014). *Couple and family therapy: An integrative map of the territory.* Washington, DC: American Psychological Association.

May, R. (1975). *The courage to create.* New York: Norton.

Minuchin, S., Reiter, M. D., & Borda, C. (2014). *The craft of family therapy: Challenging certainties.* New York: Routledge.

Nielsen, A. C. (2016). *A roadmap for couple therapy: Integrating systemic, psychodynamic, and behavioral approaches.* New York: Routledge.

Norcross, J. C., & Alexander, E. F. (2019). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (3rd ed. pp. 3–27). New York: Oxford University Press.

Pinsof, W. M. (1995). *Integrative problem-centered therapy.* New York: Basic Books.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J. L., Rampage, C., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples, and families.* Washington, DC: American Psychological Association.

Scheinkman, M. (2008). The multi-level approach: A road map for couple therapy. *Family Process, 47,* 197–213.

Scheinkman, M., & Fishbane, M. (2004). The vulnerability cycle: Working with impasses in couple therapy. *Family Process, 43,* 279–299.

Schneider, K. J., & Krug, O. T. (2017). *Existential–humanistic therapy* (2nd ed.). Washington, DC: American Psychological Association.

Sexton, T., Gordon, K. C., Gurman, A., Lebow, J. L., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. *Family Process, 50,* 377–392.

Simon, G. M. (2003). *Beyond technique in family therapy: Finding your therapeutic voice.* Boston: Allyn & Bacon.

Snyder, D. K., & Mitchell, A. E. (2008). Affective reconstructive couple therapy: A pluralistic, developmental approach. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 353–382). New York: Guilford Press.

Solomon, A. H. (2017). *Loving bravely: 20 lessons of self-discovery to help you get the love you want.* Oakland, CA: New Harbinger.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* New York: Guilford Press.

Steinglass, P. (1987). A systems view of family interaction and psychopathology. In T. Jacob (Ed.), *Family interaction and psychopathology: Theories, methods, and findings* (pp. 25–65). New York: Plenum Press.

Stiles, W. B., Honos-Webb, L, & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5,* 439–458.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

CHAPTER 16

Gottman Method Couple Therapy

John Mordechai Gottman and Julie Schwartz Gottman

BACKGROUND

We believe that couple intervention must be grounded in basic research. When we began this work in the 1970s, there were only a handful of studies dedicated to understanding why some couples sustained their marriages, while others did not. Unfortunately, those studies gave no clue as to how to proceed with intervention. For example, Newcomb and Bentler (1980) found that clothes-conscious women were less likely to divorce, but there was no such correlation for men. The types of correlations, even when significant, were quite small. Imagine, as a humorous aside, a therapy based on these results. The therapist would discuss Martha's wardrobe with her but tell George that it did not matter in his case. Men, it doesn't matter what you wear. Women, go shopping.

Therefore, we begin this chapter with a brief review of the empirical work that underlies our therapeutic methods. This work has been conducted over the last four and a half decades and continues today. Fundamentally descriptive, it arises from the notion that to understand couples, one must follow them for long periods of time to investigate change and stability. We wanted to observe not only distressed relationships but also well-functioning mixed-sex and same-sex relationships. Understanding good relationships has helped us define the goals of couple therapy because we believe that clinicians should rely on reality and not fantasies of what a good relationship is like. John Gottman and Robert Levenson (1984, 1992, 2002) together have conducted most of this basic research. That research has formed the basis of our therapeutic work. Our overriding principle is that *informed and thorough assessment of a relationship's strengths and challenges must precede intervention*. This idea that intervention must follow from assessment is the basis of all of medicine but, unfortunately, it has not yet sufficiently caught on in couple therapy. Assessment and intervention need to be linked and informed by theoretical understanding. (See also Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin.)

But does that basic research reveal that assessing a relationship is even possible? The answer to that question is a resounding "yes." Levenson and Gottman were surprised by the enormous stability of couples' interaction over time and the data's ability to predict the longitudinal course of relationships. They were able to predict both stability and relationship satisfaction with relatively small samples of observational, self-report, and physiological data. These basic findings have been replicated many times in our laboratory and, to some extent, in other laboratories as well. On the basis of these predictions, John and Julie Gottman developed a theory of how relationships function well or fail, and methods to facilitate change in these relationships through psychoeducational, preventive, and therapeutic interventions. That fruitful collaboration has been ongoing for the past 26 years.

The Masters and Disasters of Relationships

In seven nonintervention studies with over 700 couples, Robert Levenson, John Gottman, and their colleagues identified what they later called the "masters" of relationships within representative samples of mixed-sex and same-sex couples. Couples were studied across the life course and for as long as 20 years. Observed phases of relationships included everything from the newlywed years through and beyond retirement. With Neil Jacobson and his students over a 9-year period, John Gottman also studied the extreme disaster cases, those couples with both characterological and situational domestic violence. In their own laboratory, John and Julie Gottman longitudinally studied newlyweds (Gottman, Coan, Carrère, & Swanson, 1998), the transition to parenthood, parent–infant interactions (Shapiro & Gottman, 2005), and couples parenting preschool young children (and following those children from age 4–15; Katz & Gottman, 1993). With Robert Levenson and Laura Carstensen, John started studying two groups: couples in their 40s and couples in their 60s. That study has now completed its 20th year of data collection, thanks to the persistence and funding success of Robert Levenson (see Levenson, Carstensen, & Gottman, 1993). In that line of longitudinal research, representative samples of couples in the Seattle and San Francisco Bay areas were followed longitudinally, with particular emphasis on major life transitions such as parenthood, midlife, and retirement. When the couples had children, the Gottman laboratory studied parent–child interaction and followed infants' or children's emotional, behavioral, social, and intellectual development. In all our research we also oversampled both unhappy and happy couples, so that we could have equal power across the entire range of relationship satisfaction, instead of extreme groups. Some of these parent–child and child–peer results have been reported in books titled *Meta-Emotion* (Gottman, Katz, & Hooven, 1996), and Gottman and Gottman's *And Baby Makes Three* (2007). Our parenting research has revealed an effective parental strategy we call "emotion coaching." Emotion coaching interventions have now been successfully evaluated in three randomized clinical trials in Australia by Sophie Havighurst (e.g., Wilson, Havighurst, & Harley, 2012), and in South Korea by Christina Choi (personal communication, June 1, 2020).

Also, Gottman developed, tested, and validated a set of questionnaires that arose from the Gottmans' "sound relationship house" theory. Data from these questionnaires were gathered and analyzed and compiled into online Gottman Relationship Checkup Scales. In addition, questions about the history and philosophy of the relationship, our Oral History Interview, were coded with the Buehlman coding system and found to be highly predictive over a 6-year period of divorce or stability (Buehlman, Gottman, & Katz, 1992). Other data were analyzed with methods that coded dyadic emotional interaction during conversation (Gottman's Specific Affect Coding System [SPAFF]), repair during conflict, everyday interaction in an apartment laboratory (the Bids and Turning system), parent–infant interaction (developed by A. Shapiro) and parent–child interaction. The Meta-Emotion Interview (i.e., feelings and philosophy about the emotions) also generated additional data (Gottman et al., 1996). Examples of results of this research may be found in John Gottman's books, *What Predicts Divorce?* (1994), *The Marriage Clinic* (1999), Gottman and Silver's *The Seven Principles for Making Marriage Work* (1999), Julie Gottman's *The Marriage Clinic Casebook* (2004), and John and Julie Gottman's *10 Principles for Doing Effective Couples Therapy* (2015). The accomplishments of this approach include an ability to predict divorce or stability with considerable accuracy, which has now been replicated many times, and the ability to predict eventual relationship satisfaction. These findings on divorce prediction and their replications are based on strong statistical relationships, unlike those typically found in the social sciences (Buehlman et al., 1992; Gottman, 1994). Our laboratories have been able to predict the fate of marriages in three measurement domains: interactive behavior, perception (self-report on questionnaires, interviews, and video playback ratings), and physiology.

Although Levenson and Gottman could predict divorce or stability, as well as relationship happiness or unhappiness, other researchers can now repeat these findings as well. Rand Conger's laboratory at Iowa, Tom Bradbury's laboratory at UCLA, and Jan Kiecolt-Glaser and Ron Glaser's laboratory at the Ohio State University could also predict which couples would wind up stable but unhappily married and distinguish them from the couples who eventually divorced. Kiecolt-Glaser and her colleagues at the Ohio State University studied newlyweds in their first year of marriage. They used a unique procedure in which they took very small quantities of blood from the couple as they discussed an area of conflict in a hospital setting. They could later measure the couple's hormones and neurotransmitters in their blood in real time, *as they argued*. Then they followed these newlyweds for 10 years. They found that those couples who *eventually divorced—in their first year of marriage* during the conflict discussion (that's 10 years prior)—secreted 34% higher adrenaline during the conflict, 22% more adrenaline during the day, and 16% more adrenaline at night than the couples who remained married. Comparing the happy couples with what they called "the troubled," they found that, compared to the eventually happy couples, the ones who turned out 10 years later to be troubled had secreted 34% higher adrenaline during the conflict, secreted 24% more adrenaline during the day, and 17% more adrenaline at night. Note that they were predicting the fate of these newlywed couples 10 years later, just by measuring adrenaline and noradrenaline in their blood during their first year of marriage! They examined another stress hormone called ACTH (adrenocorticotropic hormone), which is responsible for releasing cortisol from the adrenal cortex. Cortisol is a stress hormone that has been related to sadness, depression, excessive rumination, separation panic in babies, resignation, giving up, and helplessness. In the newlywed women ACTH was twice as high in those women who eventually wound up in the troubled marriages. The results are also quite stable across laboratories (Kiecolt-Glaser, Bane, Glaser, & Malarkey, 2003). Effective prediction of the eventual fate of romantic relationships using physiology, observational data, and self-report data is now a well-established fact. This is very good news for the premise that assessment can and should precede intervention in couple therapy.

Beyond just assessment, the studies have also yielded (1) an *understanding* of how relationships function or fail; (2) an ability to predict newlyweds' adaptations to the transitions of parenthood, midlife, and retirement; and (3) nonlinear dynamic difference and differential equations for mathematical modeling of marital interaction.

More recently, Gottman, Gottman, Cole, and Preciado (2019) reported the results of an international questionnaire study with over 40,000 couples (which included both mixed-sex and same-sex couples) about to begin couple therapy. Before beginning therapy, all couples were assessed using the Gottman Relationship Checkup Scales. These scales had been previously validated against multimethod data gathered from our coded Oral History Interview and SPAFF emotion coding of couples' conflict interactions. The Relationship Checkup Scales proved valid and reliable for couples of all sexual orientations. The overall conclusion of this article was the fact that the couples we clinicians see every day are far more disturbed than the samples recruited in typical studies of couple therapy. Previous studies usually screened out comorbidities and tended to recruit happier and generally healthier couples.

Our basic research program has yielded nine fundamental conclusions that, in some ways, depart dramatically from past thinking:

1. By repeatedly bringing couples back to the laboratory over many waves of data collection, we conclude that most relationship conflict issues (69%) are not solvable but instead are perpetual problems.
2. Gridlocked conflict is not characterized by negative affect reciprocity but by its *escalation* from mild negative affects (e.g., whining) to the more extreme "Four Horsemen of the Apocalypse" (criticism, defensiveness, contempt, and stonewalling).
3. Escalating conflict may characterize couples who divorce early (about 5.6 years after the wedding), but there is a second destructive, emotionally disengaged interaction pattern that involves the absence of both negative and positive affect during conflict, and a lack of emotional vitality. These couples divorce later, an average of 16 years after the wedding. This later-divorcing pattern points to the important role positive affect plays during healthy conflict.
4. A gentle approach (gentle "startup," accepting influence, and compromise) distinguishes the masters from the disasters of relationships, as does neutral interaction during conflicts, low levels of physiological arousal, the use of shared humor (where both partners laugh together) and affection. The latter two serve to reduce physiological arousal.
5. Over time, physiological arousal is predictive of deterioration, whereas physiological calmness is predictive of improvement in relationships. We have shown that physiological arousal *must be considered* when analyzing conflict in couples. Furthermore, research shows that no one can intuit a person's physiology.
6. The basis for couples having a constructive dialogue about a perpetual issue and reaching a temporary compromise lies in dealing with the gridlocked conflict's core existential nature, or what we call the "dreams within the conflict" of each partner relevant to their specific issue.

7. Both down-regulating negative affect and building positivity in the relationship (during both conflict and nonconflict contexts) are essential to ensure lasting change.
8. Friendship processes, as well as effective management of conflict, control the effectiveness and thresholds of the immediate repair of problematic interaction (conflict and regrettable incidents).
9. The couple's construction of a "shared meaning system" facilitates stability and happiness. Shared meaning is built with rituals of connection, shared goals, supporting the roles we all play in life, and shared values and life philosophies. All three systems, and their interactions, need to be understood.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP: THE SOUND RELATIONSHIP HOUSE THEORY

Arranged in a pictorial order, we propose seven relational processes in our "sound relationship house" theory. There are also two "weight bearing walls" of the house, trust and commitment. One distinguishing feature of the theory we built together is that every construct in the theory can be measured accurately in our laboratory, and now in a therapist's office (or online) as well. The "sound relationship house" concepts also generally extend to the masters and disasters of gay and lesbian relationships. The house is just a friendly picture, but it guides all of our therapy.

1. Build love maps. A love map is a road map of one's partner's inner world, built by asking open-ended questions.
2. Build the fondness and admiration system by expressing affection and respect in small, everyday moments.
3. Turn toward instead of away or against by noticing and responding to a partner's bids for emotional connection.
4. Allow positive sentiment override, which results in not taking negative partner actions personally, or give the partner the benefit of the doubt.
5. Take a two-pronged approach toward managing conflict by (a) using a gentle approach in presenting complaints, accepting influence, physiological soothing, and compromise, and (b) establishing a dialogue with perpetual problems that examines and honors the existential dreams of both partners within the conflict.
6. Honor one another's individual, and perhaps unshared, life dreams.
7. Build the shared meaning system by establishing formal and informal rituals of connection, supporting one another's life roles, creating shared goals and values, and common views of essential symbols of love (e.g., What is a home? and What does love mean?).

Our recent research has employed Caryl Rusbult's profound game theory investment/commitment model in two of our own studies; in our studies, we used game theory to find what is called "the Nash equilibrium" (the optimal solution for *both* people, meaning that strategy in which neither partner can do better by switching behavior) in couples' interactions with our video-recall rating dial set as the "payoff" in a behavior exchange matrix. The Nash equilibrium is the optimal solution for both partners. Using machine learning, we are now able to do automated real-time SPAFF emotion coding, matching human coders, and providing feedback to couples and therapists. After we validated these two metrics using multimethod criteria, it was possible to discover empirically what couples actually do to build trust and loyalty. That research led to our version of the concept of "attunement." Attunement builds trust. Attunement involves listening to and processing all of the partner's negative emotions nondefensively, with empathy. This research showed us how couples actually build commitment (see Gottman's *The Science of Trust*, 2012). These basic research findings informed our intervention for helping couples recover from an affair. Recently, we have conducted intervention research treating infidelity using this research on trust and betrayal. This new therapy is called the "atone–attune–attach" model, and it is currently evaluated in a randomized clinical trial in our laboratory, in collaboration with Paul Peluso.

Based on these findings, rather than offering a checklist of what needs to be changed in ailing relationships, we present our theory of how marriages either work or fail, then discuss our interventions based on this theory. In our view, a "theory" must provide a "recipe" for creating therapeutic change and must try to describe the push–pull causal processes through which relationships work or fail. We take a humble view of our theory. We want our approaches to be useful to therapists of all orientations. The "sound relationship house" is just our best way of organizing our empirical findings plus those of other relationship scientists.

THE PRACTICE OF GOTTMAN METHOD COUPLE THERAPY

Overview

We couple therapists are both emotion scientists and therapists. So it's important to understand the intricacies of how partners turn toward each other's bids for emotional connection. We have augmented our theory with the knowledge provided in the late Jaak Panksepp's superb guides to the unexplored world of both positive and negative affect in mammals, his masterpiece book *Affective Neuroscience* (Panksepp, 1998). Panksepp (1998) documents seven affect systems that have distinct behavioral and neurophysiological patterns shared by all mammals. We call these systems "emotional command systems," and we named them. These emotional command systems are close to Panksepp's, with a few of our own modifications.

1. The Sentry, with the primary affects of fear, being vigilant for danger, and its opposite, the feelings of security and feeling safe. The primary neurotransmitter of this system is norepinephrine, and the primary hormone of it is epinephrine (also called adrenaline).

2. The Nest Builder, with the feelings involved in bonding, security, affection, love, connection and attachment, and the opposite emotions of separation–distress/panic, grief, sadness, depression, and loss. The primary hormones of this system are cortisol, oxytocin, and vasopressin. Unlike Panksepp, we include grief and separation panic in this emotional command system because we think that grief is proportional to prior attachment. We grieve loss and separation to the extent to which we were previously attached. That assertion is untested.

3. The Explorer, or the *seeking system*, with primary affects of curiosity and the joy of learning, exploration, and adventure; the primary affect of this system is the sense that something wonderful is about to happen (also, in a more limited view, called the anticipation or expectation of reward). The primary hormones and neurotransmitters of this system are glutamate, norepinephrine, and especially dopamine. Olds and Milner (see Milner, 1991) called this system the "pleasure center," but Panksepp demonstrated convincingly that it is the seeking system that is activated. This system does not satiate like other drives.

4. The Commander-in-Chief, with its primary affects of anger, hostility, rage, dominance, control, a sense of competence, confidence, and high status, and its opposites of submission and helplessness. The primary hormones of this system are testosterone and epinephrine.

5. The Sensualist, with affects involving desire, sensuality, sexuality, and lust. The primary hormones of this system are testosterone, oxytocin, and estrogen.

6. The Jester, with affects related to play, fun, humor, amusement, a sense of the absurd, mockery, laughter, and joy. The neurotransmitter of this system is dopamine.

7. The Energy Czar, which is involved in managing bodily needs concerned with energy, food, warmth, shelter, and so on. This system is primarily regulated by the hypothalamus. Panksepp did not recognize this system.

Panksepp (1998) found that something akin to these seven emotional command systems are the primary colors of affect for all mammals. The emotional command systems can operate exclusively but are often recruited in the service of one another. For example, the Explorer may be recruited in the service of finding a sexual partner. Or the Sentry and the Nest Builder may be employed along with the Commander-in-Chief to create a potentially ferocious protector of the young. We believe that these systems form the affective underpinnings for sound relationships. In other words, because every individual possesses preferences for activating these systems to varying degrees, they color the relationships between individuals. Through pure forms or blends, they color all interactions with relative affective richness. This view implies that we do not believe that anger and hostility are "basically" fear. Anger is a primary "approach emotion," very different from the "withdrawal emotions" of fear, sadness, and disgust. See Davidson and Begley (2012) for information about the separate frontal electroencephalographic (EEG) asymmetries and physiologies of approach and withdrawal emotions; fear, disgust, and sadness are primarily activated on the right hemisphere, while interest, amusement, curiosity, and anger are primarily activated on the left hemisphere. This finding has been replicated by Davidson (Davidson & Begley, 2012).

These systems plus environmental factors also create an individual's attitudes, values, and feelings about the expression of various emotions, which we call "meta-emotion." When individuals enter into relationship with one another, they form unique meta-emotion combinations. In the masters of relationship, partners are often well matched in meta-emotion, or they have found ways to coexist harmoniously with meta-emotion mismatches. But in couples who experience distress, meta-emotion mismatches have often disrupted the relationship. These mismatches are often the basis for escalated conflicts. Distressed couples often present in therapy with meta-emotion mismatches. Without intervention, Katz and Gottman (1993) found that these mismatches predict divorce with 80% accuracy. Yet, in treatment, these mismatches are not insurmountable. The couple needs to create a common emotion culture that honors each partner's own beliefs, past traumas, experiences, and values about the role of emotional communication. Emotional communication and behavior primarily have meaning within social interaction. A contextual relationship focus was the basis for our SPAFF cultural informants' emotion coding system. For example, if a husband displays an angry facial expression and that is followed by his wife's angry facial expression, the second expression could be coded as either anger or empathy, depending on the words that accompany the facial expressions.

The Structure of the Therapy

We begin each therapy session with the concerns and emotions that a couple brings into the therapeutic hour, building the relationship by using these emotions in the context of an empathic and accepting therapeutic alliance. Like Johnson's (2004) emotionally focused couple therapy (EFT; see also Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan), our therapy is emotion-focused, experiential, and centered in the here and now. Using the Relationship Coach videos and handouts, we provide the couple with explicit "blueprints" we have gleaned from the masters of relationship for downregulating negative conflict, enhancing positive affect, and creating shared meaning in the relationship. There are three conflict blueprints, one for dealing with current conflicts, one for dealing with past conflicts and emotional injuries, and one for dealing with conflicts that have an existential basis (which we call "gridlocked" conflicts). Teaching physiological self-soothing and building each partner's vagal tone are also essential because effective communication is powerfully undermined by partners being flooded (in fight-or-flight physiology); our therapists often use pulse oximeters to measure heart rate and percent oxygen in the blood to determine whether partners are flooded in the moment, so appropriate treatment measures can be taken. Sessions online will soon be able to employ heart rate measured directly from video. These "blueprints" provide the therapist and the couple with a guide that makes explicit the skills necessary to accomplish therapeutic goals. The therapist makes the therapy process as dyadic as possible, serving as a validating, compassionate emotion coach, and a "translator" of the feelings and needs of each person in the interaction (see Wile, 1988). The therapist also explains and teaches constructive alternatives to the couple's ineffective patterns of interaction. The Relationship Coach will also soon be also available to couples on their cell phones for between-session crises interventions or homework (see *www.gottmanconnect.com*).

Process and Technical Aspects of Gottman Couple Therapy

Goal 1: Down-Regulate Negative Affect during Conflict

We have found that conflict is inevitable in relationships. It has many prosocial functions, such as culling out interactions that do not work, helping us to know one another as we change, and continually renewing courtship. Therefore, we do not declare war on negative affect, or try to eliminate it. We know that behind every negative affect there is a longing, a wish, or a positive need. Taken directly from the research, an example of this escalating negative affect follows:

WIFE: I wish you'd stop laughing. Makes me so mad that I'm late every morning because you won't get up on time.

HUSBAND: (*sad, tense voice tone, avoiding eye contact*) Yeah, I shouldn't laugh. I know what it feels like to be late because of someone else.

WIFE: (*angry*) Oh, do you know what it feels like?

HUSBAND: Yeah, I sort of know what it feels like.

WIFE: (*mocking, contemptuous*) You sort of know what it feels like, you sort of know what it feels like. (*intensely angry*) Then why don't you show a little respect for me?

In this short interaction, the husband's nervous laughter appears to mock the wife's anger, which is contemptuous behavior on his part, and she subsequently responds by escalating her anger to mockery and contempt. This dialogue highlights the importance of deescalating conflict.

BUSTING MYTHS ABOUT CONFLICT

We have learned a great deal about conflict in the past four decades. In 1965, Bach published *The Intimate Enemy*, in which he suggested that couples need to express their resentments toward one another, and that great harm can come from suppressing anger. He believed in a catharsis theory of marriage. He had partners take turns expressing their resentments toward one another, and even had them hit one another with foam-rubber bats called "batakas." At the end of one of his sessions, however, people left even more resentful and angry than before they came in for therapy. There is no evidence for a catharsis theory of anger expression. Anger must be guided to become constructive.

Our research indicates that there is only one form of dysfunctional relationship conflict, which is called an "absorbing state" of negative affect. Unhappily married couples enter an "absorbing Markov state" of negative affect, meaning that it is easier to enter that state than it is to exit. Both entry and exit from negative affect are different for unhappily compared to happily married couples. Contrary to Bach, the masters of relationship begin the first 3 minutes (which we call "startup") much more gently than the disasters.

What is the alternative to Bach's approach? We have learned that in stable, satisfying relationships, people take a gentle approach to conflict. They soften the way they bring up issues. They are influenced by one another (which is easier to do if the issue is presented gently). They emphasize their common ground. There is give and take, mutual influence. They use neutral and positive affect and constructive conflict management and problem solving to down-regulate both their own and their partner's physiological arousal. They reach a compromise. They attempt to repair ruptures early and to accept repair attempts. These findings led us to a *blueprint* for constructive conflict discussions that have suggestions for both listener and speaker.

PERPETUAL UNSOLVABLE CONFLICTS

Our knowledge about conflict itself has also deepened. The focus in many couple therapies is primarily about "conflict resolution." The therapist sees the goal as helping partners "resolve" their issues and put them away forever. However, we have learned in our research that 69% of couple conflicts are perpetual. They never get resolved. Bring a couple into a laboratory 4 years after the first time and the partners are talking about the same issues in very much the same ways, albeit often in different forms. When current and past videotapes are edited together, it looks like no time has passed at all. These conflicts have lasting sources that arise from consistent personality and need differences between partners. In his remarkably insightful book *After the Honeymoon*, the late Dan Wile (1988) wrote that "choosing a partner is choosing a set of problems" (p. 12), problems are a part of any relationship, and a particular person would have some set of problems no matter who that person married.

So, we think that it is the case that relationships (without therapy) work to the extent that people have chosen a relationship with a set of perpetual problems with which they can learn to live. Well-functioning relationships establish what we call a "dialogue" regarding these issues. Partners keep revisiting them and talking about them with humor, affection, and some irritability, but without escalating negative affect.

For many couples, these perpetual issues seem to arise out of thin air. In hundreds of research interviews about conflict at home, we also found that couples do not necessarily argue about "issues." There may be no topic to the argument. The conflict, as in the following example, appears to be about the interaction itself:

WIFE: Stop channel surfing. Just leave it. I want to see this show.

HUSBAND: (*holding the remote*) Let me just see what else is on.

W0IFE: No. I might want to watch this show.

HUSBAND: In a minute. There could be a film on.

WIFE: Leave it.

HUSBAND: Fine!

WIFE: That's your problem, the way you just said "Fine"? Why did you say that? We were having a perfectly good time until you said that.

HUSBAND: I said "fine" because, have it your way, you're going to have it your way, anyway.

WIFE: Fine!

On the surface, this fight is about nothing. However, a deeper look suggests that there are hidden agendas based on accepting differences and power.

METHODS FOR ACCOMPLISHING GOAL 1

Here are a number of interventions that can be used to downregulate negative affect.

Step 1. Repair—Processing Fights and Regrettable Incidents. Our analyses of over 900 videorecorded conflicts in our laboratory and over 1,000 play-by-play interviews about conflict at home have led us to conclude that, most of the time, couples fight about what appears to be absolutely nothing (Gottman & Gottman, 2007). Couples often come into a typical therapeutic hour with a combination of successes and hot regrettable incidents (conflict or failing to connect emotionally). These become one focus of therapy. Conflicts usually arise from mismatches in perception and need in everyday interaction that very rapidly lead to misunderstanding, hurt feelings, escalation, anger, pouting, sulking, and emotional withdrawal (Robinson & Price, 1980). One or both people say and do things that they later regret. Processing regrettable incidents such as these is an essential part of conflict management. We focus on the emotions and perceptions in these events.

Our "Aftermath of a Fight or Regrettable Incident" format involves both people agreeing that in a regrettable incident, there are two subjective realities, both of which are right. Even if we have people view a videotape of their interaction, there will still be two very different subjective realities about the interaction. Processing a fight means being able to talk about it without getting back into it. As William Faulkner wrote in *Requiem for a Nun* (1984), "The past is never dead. In fact, it isn't even past." So, fortunately, it is possible to revisit the past and reprocess the emotional wounds created in these regrettable incidents. This may require some physiological soothing. Then the partners process the regrettable incident by (1) taking turns talking about their feelings and needs during the incident; (2) taking turns describing their subjective realities and validating part of their partner's reality; (3) explaining what old feelings from the past may have been triggered during the incident; (4) admitting their role in the conflict, taking responsibility, and apologizing; and (5) talking about one way to make a similar conversation better next time. The therapist assists by building acceptance, empathy, and understanding.

An important step in processing is to understand the fight by mapping what we call "the anatomy" of the fight. This involves identifying the "triggers" for each person that escalated the conflict and unearthing the original emotional injuries that caused them, usually dating back to childhood (i.e., understanding why these are triggers). These triggers are made public parlance for the couple, whereby partners can experience empathy for one another and soften their response accordingly. Thus, an alliance between the partners can be built from understanding the conflict itself. Past traumas are revealed in these triggers, a couple-based approach to treat comorbidities.

Repair will be ineffective, however, if the couple is in a state of "negative sentiment override," in which accumulated resentment renders understanding impossible to achieve. Then, additional work must accompany repair work.

Step 2. Reducing the Four Horsemen. A 5:1 positive-to-negative interaction ratio characterized the conflict discussions of happily married couples, compared to a 0.8:1 positive-to-negative ratio of unhappily married couples. Some of the negative behaviors were more corrosive than others. John Gottman labeled four of these behaviors, "The Four Horsemen of the Apocalypse." By heightening partners' awareness of the four best predictors of relationship meltdown, the "Four Horsemen of the Apocalypse" plus their "antidotes," the therapist can also gentle-down conflict interaction. Sometimes the therapist stops the couple when the Four Horsemen appear and works on their antidotes, but not every time. For some couples, the Four Horsemen are wreaking such havoc on interaction that constantly stopping them could render the couple stone silent. So the therapist uses discretion about when to stop but always does so when there is verbal contempt (name-calling, direct insults). The first horseman, "Criticism," is stating a problem as a deficit in the partner's character. The antidote for criticism is complaining by talking about what one feels ("I" statements, no "you" statements, no blaming) about what specific situation and expressing a positive need. A positive need is a specific way that one partner can shine for the other. For example, if a man is upset that his partner talked at dinner about her day, a criticism would be "You are so selfish. All you think about is yourself." The antidote or alternative way to express the complaint would be "I'm upset about the conversation at dinner. I need you to ask me about my day." If a partner has trouble voicing needs, the "expressing needs" card deck can help by offering a broad spectrum of needs from which to choose. This card deck and 13 others can be downloaded as a free phone app at the Apple App store by asking for "Gottman Card Decks" (currently downloaded 350,000 times).

"Defensiveness," the second horseman, offers a form of self-protection through whining ("innocent victim" stance) or counterattacking ("righteous indignation" stance). The antidote for defensiveness is taking responsibility for even a small part of the problem. For example, if one's partner has said, "I hate you being late. I need you to be on time," a defensive statement would be a counterattack: "You think you're so perfect? So when did you last balance the checkbook?" Accepting responsibility would sound like "That's a good point. I do take longer than you'd like." It is also important that the therapist help partners acknowledge responsibility without also feeling criticized by the therapist. Down-regulating defensiveness may be the greatest challenge in relationships.

"Contempt," the third horseman, is a statement made from a position of superiority that often includes sarcasm, direct insults, or name-calling, or something more subtle (e.g., correcting someone's grammar when the person is angry). It is essential that the therapist not empathize with statements of contempt; to do so runs the risk of creating a collusion with abuse. The therapist needs purposely to stop any insults, put-downs, or name-calling, then define these as contempt and tell the couple that contempt is our best predictor of relationship dissolution. The masters of relationship may regularly demonstrate the other three horsemen (at low levels), but they rarely voice contempt. The antidote for contempt is not only the absence of contempt but also the presence of respect. The therapist must help the couple create a culture of appreciation and admiration, which is not a quick fix. This involves teaching partners how to have a positive habit of mind in which they scan the environment for actions of the other to appreciate and respect. The therapist can begin by having each partner express appreciations for one another either spontaneously or by using our "Expressing Appreciations" card deck. Over time, couples can learn to see the good in their partners, not the contemptible.

The fourth horseman, "Stonewalling," is emotional disengagement from interaction. We observe this in the laboratory in the absence of cues that a listener is tracking the speaker (e.g., head nods, brief vocalizations, facial movement); the listener seems like a stone wall. The antidote for stonewalling is self-soothing to reduce one's own physiological arousal and staying emotionally engaged. To decrease stonewalling within sessions we use (1) physiological monitoring (with two pulse oximeters), asking people about their own inner monologue during arousal (in stonewalling, this monologue is usually about emotional withdrawal); (2) "focusing," so that people can learn to articulate the nuances of what they are feeling and what their bodies are telling them; (3) relaxation and meditation training within the couple session, actively asking the partners questions; and (4) biofeedback (HeartMath's Emwave2).

Another method we use for soothing is to teach the partner to do the soothing. We think this method is far superior to having the therapist do the soothing. The therapist cannot be there in important emotional moments of flooding and stonewalling. In the natural environment, stonewalling might be accompanied by a partner actually leaving the scene of the physiological arousal; this escape serves to condition new trigger signals associated with the arousal (e.g., the partner's voice, the partner's smell, the partner's presence). Teaching the physiologically aroused client to self-soothe in the presence of the partner, and teaching the partner to soothe the client, has the potential to reverse the escape conditioning that stonewalling offers. Rather than calm people down to make an interpretation, we stay with the emotions of the moment.

Step 3. The Speaker–Listener Method. We need to establish emotional safety for partners by postponing persuasion until each person can state the partner's position to that partner's satisfaction. The couple first postpones persuasion. This blueprint is not like mirroring, it is more macro. The listener reflects back the partner's entire position, not the most recent paragraph, and adds some genuine validation. The goal is to make conflict discussions at the outset gentler. We use an exercise that includes responsibilities for both the speaker and the listener. Here is the simple blueprint: Each partner is given a clipboard with paper and pen. The speaker expresses feelings using "I" statements (not "you" statements) about a specific issue and states a positive need, in other words, what the person does want. This requires a mental transformation. The therapist may need to help convert blaming, "you" statements into feelings about a specific situation and a positive need. Next, the listener has to be able to state the speaker's feelings and needs to the speaker's satisfaction and, at least to some degree, to validate them. The therapist often needs to aid the listener here. We give clients a small, laminated blueprint card that lists speaker and listener roles, so they can also practice at home. Mutual understanding is the goal. Expressing needs as a weekly ritual of connection accompanies this blueprint.

Step 4. Identify Dreams within Conflict. This intervention is for conflicts that are "deal breakers," when to one or both people the very thought of compromise seems like giving up some central part of one's values or personality that one treasures, and then compromise, in essence, feels like giving up one's self. At these times, there is a control struggle in which each person's position is interlaced with deep symbolic meaning and dreams that lie camouflaged beneath the surface. We use a method to unearth these hidden nuggets that, again, employs a listener–speaker exercise and provides the listener with six specific questions.

Step 5. Problem Solving, Persuasion, and Compromise. Once partners understand each other's positions and feel validated and understood, persuasion can begin. Then, the couple can move toward problem solving and compromise. We use our "two-circle" method to facilitate compromise. The therapist hands each partner a diagram of two concentric circles, which looks like a bagel. Each person is asked to identify a core need in the issue on which they *cannot* compromise. These needs are written inside the inner circle. Then each partner writes down aspects of the issue on which they have more flexibility. Finally, the partners share what they have written with one another and discuss a compromise, using a series of questions that they are given, like finding their common goals and feelings. The idea is that compromises fail if people give up too much that is crucial to them, so safety is established by first helping partners identify their core needs and communicating why these needs are so central, then identifying areas of greater flexibility in which there can be movement toward compromise.

Step 6. Down-Regulating Negative Affect with Physiological Soothing. One replicated finding in Levenson and Gottman's (1983) research is the important role of physiological soothing in down-regulating negative affect. These findings suggest that methods for muscle relaxation, deep breathing, meditation, and biofeedback may be helpful in couple therapy. In our offices, in addition to video cameras for replay and discussion within the therapeutic hour, we each have two pulse oximeters that measure the beat-to-beat heart rates and oxygen concentration in each person's blood during a conflict discussion. The oximeters have an alarm we can set that beeps when a partner's heart rate exceeds the intrinsic heart rhythm and a person is likely to start secreting adrenaline. This intrinsic heart rate is 100 beats per minute (bpm) in normal people and 80 bpm in highly trained athletes. Small and inexpensive U.S. Food and Drug Administration (FDA)–approved oximeters are now available online that therapists can use. At these elevated rates, the oxygen concentration may also go below 95%. During the session, when the oximeters beep, clients know that they are physiologically aroused, or flooded, and need to calm down before proceeding. They are guided by the therapist to deep-breathe, do paced breathing together, do muscle relaxation work, or do guided visual imagery to help them in that process. Once their heart rates return to more normal levels, they continue the therapeutic work. This system of biofeedback enables partners at home to begin to sense when they are flooding and need to take a break. Their new sensitivity to body responses enables them to down-regulate escalations that may occur at home during conflict.

Goal 2: Up-Regulate Positive Affect during Conflict

Devitalized couples didn't express the Four Horsemen, but their interaction was typically sad and energy-less. For example, one couple in the study said the following:

WIFE: In all the years we've been married, seems to me that you don't know very much about me at all (*distressed tone, angry, whining*).

HUSBAND: (*avoiding eye contact, long pause, then in a neutral voice tone*) Yeah, that's pretty much true about the both of us.

In that interaction, the importance of the husband's response can be seen by imagining the alternative response of an engaged husband:

IMAGINED HUSBAND: Oh no, that's a terrible way to feel. No wonder you're upset. Let's talk about that and put an end to your feeling that I don't know you. I want to know you. It's very important to me.

What is surprising about this interaction is that the wife's complaint is actually a bid for connection. What makes it so dramatic is that the husband, instead of responding with alarm, concern, or empathy, responds with sadness and resignation.

THE IMPORTANCE OF AGREEMENT, OR JUST SAY "YES, DEAR"

Imagine a saltshaker filled with words and nonverbal actions that communicate all forms of agreement, affirmation, acceptance, validation, verbal, and nonverbal ways of saying "yes" (e.g., "Yes," "You're right," "Good point," "What are your concerns here?" "You're making total sense," "That's so smart," "Okay," "I can agree with some of what you're saying"). Levenson and Gottman (1983) also discovered that during conflict, an affectively *neutral* way to present and respond to complaints is also a way of saying "yes"; it is actually positive. Untrained observers tend either to ignore neutral affect during couples' conflict as unimportant or to view it as boring; therefore, they are poor at predicting from videotapes of couple conflict which couples will divorce and which will stay together. But now imagine sprinkling the "Yes" saltshaker throughout the conflict interaction over time. That characterizes the interaction of stable, satisfied couples. Now imagine another saltshaker filled with words and nonverbal actions that communicate all forms of disagreement, ways of saying "No" (e.g., "No," "You're wrong," "You're so cold," "You're a total jerk," "What's wrong with you is . . . ," "You are the problem," "You never . . . ," "You always . . . ," "I'm right," "Screw you," "You bitch," "That's ridiculous!," "Let me tell you what your problem is," "You're completely irrational," "I disagree with everything you're saying," "You are so stupid," "Yes, but . . . "). Now, imagine sprinkling the "No" saltshaker throughout the conflict interaction. That characterizes the interaction of unstable, dissatisfied couples.

The interaction of the masters of relationships is characterized by some of the words and actions in this "No" saltshaker, just fewer of them, and, in fact, it is counterbalanced by five times more from the "Yes" saltshaker (Gottman, 1994), and effective repair at a lower threshold of negativity. The masters are particularly low on contempt. However, it would be a mistake for clinicians to declare war on negative affect based on these results. Like predators in an ecology that cull out the weakest of the prey species, negative affect can cull out those parts of interaction that are not working. Negative affect can improve the relationship over time, if it is followed by accepting influence. It is essential that the partner respond to negative affect with reflective listening, increasing the partner's "carrying capacity" for negative affect. Anger expressions can reduce unfairness and injustice in the relationship, for example. Negative affect happens in all relationships, and behind every negative affect is a longing, or a positive need. In good relationships, negative affect is also counterbalanced by positive affect, and by repair. One characteristic of the masters of relationship is a lower threshold for repair. They repair before the interaction gets too negative.

In an apartment laboratory, we were able to study the relationship between nonconflict interaction during everyday moments in a 10-minute dinnertime, and both negative affect and positive affect during conflict. Analyzing the more than 600 hours of video generated in the apartment laboratory took nearly a decade. Driver assessed the response to what her coding system called "bids" for "emotional connection" (verbal and nonverbal attempts to get one's partner's attention, conversation, interest, enthusiasm, humor, affection, playfulness, emotional support, etc.; Driver & Gottman, 2004). Driver found, among other things, that couples who stayed together after 6 years had initially (in the first year of marriage) turned toward one another's bids for emotional connection about 86% of the time, whereas couples who later divorced had turned toward their partner's bids only 33% of the time. Furthermore, those couples who turned toward one another's bids at a higher rate had less negative affect and more positive affect during a conflict discussion, particularly more shared humor and affection.

Driver's findings are important because we need to know how a therapist can build a couple's positive affect during conflict. It is clearly not effective simply to tell partners to laugh more the next time they discuss his mother. Furthermore, we claim that it is much more difficult to change a couple's interaction during conflict than to change the mostly neutral interaction of turning toward bids for connection. The therapist's initial task may not be so much to build positive affect as to get people to *notice* the positive affect that is already there. Bradbury's systematic research on newlywed interactions also supported the importance of positive emotional support in a relationship, which added significantly to the prediction of the fate of these relationships over and above data from conflict interactions (Kuhn, Bradbury, Nussbeck, & Bodenmann, 2018).

Goal 3: Build Positive Affect during Non-Conflict Interactions

THE WORLD OF POSITIVE AFFECT

Turning toward bids for emotional connection opens up an entire world of positive affect that we have yet to fully explore in couple research. The universe of positive affect includes far more than turning toward one's partner's bids or building love maps, or fondness and admiration. There has been a hidden assumption in couple therapy: If we adequately deal with couples' conflicts, a sort of vacuum will be created, and all the positive affects will rush in to fill this void. We suggest that this assumption is wrong. Positive affect systems need to be built separately in therapy. In our research on the effects of the first baby on the couple's relationship, for example, we found that the first positive couple interactions to vanish are play, fun, exploration, adventure, curiosity, self-disclosing conversations, romance, courtship, female libido, and good sex. Over 80% of couples beginning therapy reported that fun had died in their relationship; the other prominent victims were romance and adventure.

We suggest that *the savoring* of positive affect in multiple positive affect systems is what builds a wonderful and secure relationship, as well as attachment and security. Therefore, we propose the following hypothesis: Once negative affect is down-regulated, positive outcomes in relationships are a result of being able to savor positive affect. But we need a guide to this world of savoring positive affect. What is "savoring"? We suggest that the secret of savoring comes from an understanding of the two ways infants respond to incoming information and energy. One way infants respond to incoming information and energy is Sokolov's orienting reflex (see Ushakova, 1997). We call it the "Oh, what's this?" response. This is an opening to information and energy that in the infant involves a heart rate reduction, pupil dilation, suspension of sucking and self-soothing behavior, and behavioral stilling. The other way infants respond to incoming information and energy is a defensive response. We call it the "What the hell is this?" response. This is a closing to information and energy that in the infant involves a heart rate increase, pupil constriction, an increase in sucking and self-soothing behavior, and behavioral activation (e.g., pumping the limbs). One part of savoring is an openness to information and energy. The other part of savoring is a heightened awareness of sensual responding, taste, smell, touch, and access to sensual memories. The positive and negative affect systems are related. Just as relaxation is an antidote to anxiety, negative affect eliminates savoring, whereas savoring acts as a powerful antidote to the experience of negative affect. We have noticed that devitalized couples have generally shut down not only sex and romance but also all the positive affect systems. Therefore, it may not be adequate with devitalized couples to do only sex therapy.

EMOTIONS AND CURRENT NEUROSCIENCE

Modern neuroscience research and neurological practice shows that there is an integration of reason and emotion in the prefrontal cortex, as well as bidirectional feedback with limbic areas (LeDoux, 1996; Siegel, 1999). For example, in *Descartes' Error* (1994), Damasio demonstrated that a patient who had a tumor removed from the prefrontal area was no longer able to process emotions and to use intuition, a central emotional component of problem-solving or prioritizing information. The man had lost his job and his marriage. In his initial evaluation of the patient, Damasio discovered that the man could solve puzzles and mazes well. Damasio was baffled until he scheduled another appointment with the patient, who was able to list times he was available in the following week but unable to prioritize those times and select a best time for the next appointment. Without emotion and intuition, he was incapable of prioritizing his needs and making fundamental decisions for himself. This demonstrated that rational thought is fundamentally intuitive and emotional, as well as cognitive, and that during emotional moments, people are able to think. This view is directly contrary to the idea that we have to make therapeutic interpretations when a client is in a neutral affective state because that is when the person is rational and can understand the interpretation.

Bowlby (1988) suggested that it is not helpful to pathologize strong needs for connection, nor is it helpful to pathologize relationships that select greater emotional distance and independence. There is no optimal amount of interdependence or independence, or emotionality. In our typology of couple relationships, we found that there is also no optimal amount of emotional expression, or an optimal amount of conflict engagement or avoidance. Raush's classic observational and sequential analytic work (Raush, Barry, Hertel, & Swain, 1974) on the transition to parenthood suggested that both bickering and conflict avoidant (and disinterested in psychological insight) couples were dysfunctional, and that only middle-ground "harmonious" couples were psychologically healthy. However, our typological longitudinal research found that despite his monumental contributions, Raush was wrong on this point. So long as partners are matched on the amount of conflict they desire, or wish to avoid, the amount of emotional expression and exploration they wish, and the amount of intimacy, passion, and interdependence or independence they desire, everything is fine. Their relationships turn out to be happy and stable, and their children are also fine on measures of cognitive and affective child outcome. Problems occur when there are mismatches between partners, and these mismatches create central, perpetual issues for the relationship. Problems also occur if the positive-to-negative affect ratio during conflict is lower than 5:1.

As the foundation for her research and therapy, Susan Johnson (see Johnson et al., Chapter 6, in this volume) used attachment theory, which has demonstrated that a developmental theory of increasing independence in close relationships is entirely misleading. Johnson understood that attachment theory correctly normalized dependency in close relationships. In addition, research has demonstrated that relationships are all about being emotionally connected, and that the amount of connection and emotion is a matter of personal choice and comfort. Both low and high levels of emotional connection have their own risks and benefits; neither choice is perfect. In our work (Gottman, 1994), as long as the ratio of positivity to negativity during conflict is 5:1 or greater, all relationships (passionate, validating, and conflict-avoidant) are stable. However, when the ratio of positivity to negativity during conflict falls to 0.8:1 or less, all of these relationships are unstable. Bowlby's theory (1988) has also been supported by basic research on attachment in nonhuman primates (e.g., see Blum, 2002). Harlow's groundbreaking (Harlow, 1974) research showed that love in baby rhesus monkeys is based on secure attachment, comfort, nurturance, emotional availability and responsiveness, touch, affection, and contact. It is not based on a surrogate providing milk delivered by a nipple, no matter how readily available the nipple is. Johnson understood this, too, and based EFT on the need for secure attachment, not the alleged need for differentiation.

We agree with Darwin (1873) that all the emotions are functional and serve adaptive values. Because the emotional command systems, when paired with negative affects, are also quite capable of operating independently, it is not the case that "behind" anger and rage there is necessarily a primary emotion, such as fear. The implications of this work are dramatic for the couple therapist. The royal road to intimacy is emotional availability and responsiveness. Instead of fostering a process of controlling emotion with reason in clients, couple therapy needs to focus on the integration of emotion and thinking; the understanding of emotional connection; couples' negative cycles; and the dynamics of emotional connection, turning away or against, and the dynamics of attachment betrayal.

METHODS FOR ACCOMPLISHING GOALS 2 AND 3

Our blueprint for building friendship and intimacy, and upregulating positive affect has four steps.

Step 1. Emotional Connection during Everyday Moments. The action components of building emotional connection during everyday moments follow:

1. *Building love maps*, which are road maps of one's partner's inner psychological world, formed by showing active interest and asking open-ended questions. We use Love Map and Open-Ended Questions Card Decks. More recently, we have created an exercise for creating erotic love maps for one's partner.

2. *Building a culture of appreciation and respect* by catching one's partner doing something right and thanking the person; this involves cultivating a positive habit of mind in which one partner scans the environment for things to appreciate and to respect in the other and employs politeness and consideration.

3. *Turning toward bids*, which involves building an emotional bank account by becoming mindful of the way one's partner asks for what one needs and responding positively to those needs. Bids are verbal or nonverbal requests for connection along a hierarchy of intimate interactions, beginning with getting the partner's attention, then showing active interest, having conversations, giving affection, sharing humor, and offering empathy and emotional support. This is based on the work of Driver. People who are unsuccessful at bidding and receiving a response at a lower level on this hierarchy will not make bids that are higher up, with increasing potential for intimacy. Turning toward bids is discussed in Gottman and DeClaire's (2017) *The Relationship Cure*.

4. *Emotion coaching* is about periodically taking one's partner's emotional temperature by asking a question, such as "How are you?" or "Talk to me," accepting (not dismissing or minimizing) the partner's negative emotions (especially if they are about you) and being able to engage in an emotionally satisfying conversation. Recent work on the process of "attunement" has shown that a special kind of nonjudgmental and

empathic listening when one's partner is experiencing negative affect systematically builds trust, especially if the negative affects are about the partner and that partner attunes. It also downregulates the Four Horsemen.

5. *Increasing and savoring positive affect.* A lot of positivity goes unnoticed in ailing relationships. But there is also a huge deficit in positive affect in ailing relationships. The final part of building friendship and intimacy is to build positive affect. We maintain that each positive affect system requires effort and prioritization of time. This involves the therapist helping the couple to increase the positive affect systems, such as play, comfort, humor, laughter, interest, amusement, curiosity, learning, fun, exploration, and adventure. Dealing effectively with conflict or adding insight into negative patterns, or creating bonding by healing attachment injuries, will not enhance these positive affect systems. They are separate emotional command systems (see Gottman & DeClaire, 2001) that will not flourish by themselves, unless the therapist prioritizes them. People everywhere on the planet who have a happy sex life do things like kiss their partner passionately for no reason at all, kiss one another often, give compliments and surprise romantic gifts, express affection in public, and have weekly romantic dates (see Northrup, Schwartz, & Witte, 2013). Positive affect, love, and affection need to be priorities, and need to be nourished and savored.

It is not enough for the couple and therapist to plan events that are likely to generate more positive affect because it is equally important to work on *savoring* positive affect. That is difficult for many clients, and problems in this area have a history that is worth exploring. This process of savoring is important for events that are in memory as well. It is like periodically lifting out of one's memory a many-faceted jewel, each face of which contains a lovely and loving memory of how the partner or the relationship has enriched one's life. In this way, positive events become more and more precious and indicative of what a wonderful relationship the partners have built. This is an active way that people naturally work on their cost–benefit view of the relationship and build a positive outcome on our oral history interview.

Step 2. Daily Stress-Reducing Conversation. Jacobson, Schmalling, and Holtzworth-Munroe (1987) discovered that one of the secrets to maintaining gains in couple therapy over 2 years might be for partners together to cope actively with stress outside the relationship and to buffer the relationship from these stresses. Such couples actively engaged in stress reduction. This finding was even more fascinating because stress management was not a component of the therapy. Instead, the couples who maintained gains thought of doing this themselves. This has been extended in Switzerland by the work of Bodenmann, Pihet, and Kayser (2006). In our therapy, we suggest that couples engage daily in a 20-minute stress-reducing conversation, and we help couples with guidelines for this conversation. Our motto, taken from the groundbreaking work of Ginott (2003), is "Understanding must precede advice."

Step 3. Build Affection, Good Sex, Romance, and Passion. In our research on the transition to parenthood (see Gottman & Gottman, 2007) we studied couples 3 years after the arrival of a baby. We asked them about their sex lives and found factors that differentiated between couples whose sex lives were going well in their view and those whose sex lives were not going very well. The partners whose sex lives were going well tended to (1) continue courtship and, most important, they occasionally let the partner know that they were sexually desirable to them; (2) give compliments, surprise gifts, poems, or daily messages that said, "You are special to me"; (3) express nonsexual physical and verbal affection often; (4) have an agreed-upon ritual for initiating and refusing sex; (5) have an agreed-upon way to talk about sex—often talking only about what was erotic or a "turn-on"; (6) have moments of cuddling that turn into sensual touch and massage, much like Masters and Johnson's nondemand pleasuring, and taking in sensual experience; and (7) make it a priority to engage in a wide variety of sexual activities. For example, they had "quickies" as well as gourmet sex, without having a long list of prerequisites for having sex. They said, "Yes, okay," a lot when their partners initiated sex, even if they were not totally in the mood; they accepted masturbation (together or separately); they continued oral sex; and they explored and accepted one another's sexual fantasies. To help couples work on their romantic and sexual relationship, we have written a pamphlet called Gottsex, with a manual for couples and a DVD that teaches seven skills, including a card deck for building an erotic love map of one's partner and ideas for affection, romance, and good sex that we call the three "Salsa Card Decks." These tools are available at *www.gottman.com.*

Step 4. Process Failed Bids for Emotional Connection. Just as the conflict blueprint has a method for processing fights and regrettable incidents, the friendship blueprint has a method for processing failed bids for emotional connection. These are moments when one partner turns away or against a bid for connection or turns toward a bid unenthusiastically. Most of the time when couples come into a therapy hour (or, in our case, 80-minute sessions) in one of two negative states, there has been either a fight or a regrettable incident, or failed bids for connection, or both. We use a very similar, but not identical, blueprint for processing a failed bid for connection. We also have an intervention for processing successful events in emotional connection to understand the dynamics of successful emotional connection.

Goal 4. Bridge Meta-Emotion Mismatches by Creating a Common Emotion Culture

People have reactions to being emotional and to expressing or suppressing emotion. Despite the enormous complexity of meta-emotion we observed in our research, people could be divided into two broad categories: emotion dismissing/out of control, and emotion coaching. Emotion-dismissing people believed that they could decide which emotion they would have through a force of will, a Norman Vincent Peale "power of positive thinking" view. They believed in action rather than introspection and used expressions such as "Suck it up and get on with life" or "Roll with the punches." Emotion-dismissing people generally had a poorly developed lexicon for the different emotions and often did not really know or care to investigate what they were feeling. They tended to view not having needs as a strength, and having needs as being "needy" and weak. They tended to view introspection about negative feelings as a waste of time or even as toxic. They considered emotional expression a loss of control and tended to use explosion metaphors for anger, mental illness metaphors for sadness, and weakness or cowardice metaphors for fear. They were impatient with their children's negative affect and tended to view it as a failure of their own parenting. When they taught their children something new, they waited for their children to make a mistake, then became critical, directive, and even more critical and intrusive if the child's performance worsened. Emotion-dismissing people emphasized action over introspection in any situation and tended to suppress their own needs and feelings in any situation in favor of getting things done. These people were effective at compartmentalizing and suppressing emotion (see Gottman & DeClaire, 1996).

In contrast, emotion-coaching people believe that emotions are a guide for how to proceed through life. To such people, anger meant that one had a blocked goal, fear meant that one's world was unsafe, and sadness meant that something was missing in one's life. They did not think they could or should decide which emotion they would have. They viewed emotions like a GPS (global positioning system) for action. They believed in introspection, and understanding emotions as a prelude for action, and in validating their children's emotions even when they misbehaved. Their philosophy was that all feelings and wishes are acceptable, but not all behavior is acceptable. They set strong limits on misbehavior and gave their children choices. Emotion-coaching people generally had a good lexicon for the different emotions, noticed mild forms of emotion, and believed that their children's expressions of emotion were an opportunity for intimacy or teaching. They tended to view having needs and knowing what one needs as strengths, and to view introspection about negative feelings as productive and emotional expression as positive, within limits. They were patient with their children's negative affect and thought of it as healthy, even if their children were disappointed or sad, and believed they should respond with empathy and validation of their children's feelings before problem solving or giving advice. When teaching their children something new, they waited for their children to do something right, offering genuine praise and enthusiasm before giving advice or direction. Emotion-coaching people emphasized introspection over action and tended to explore their own needs and feelings in any situation rather than getting things done.

Obviously, most people, as well as most couples, arrive at some balance of emotion-dismissing/out-of-control and emotion-coaching behavior. Often they work on defining that balance through dialogue about a perpetual issue. For example, let us say a couple is discussing the husband's fear of learning a new skill for job advancement. Empathy and support are important in helping him deal with his fear; but at some point, he will have to learn the new competence. The partner might arrive at a balance by deciding on the use of both emotion coaching and a more dismissing attitude of simply getting on with it.

In contrast, for some couples, a meta-emotion mismatch like this can be a source of great conflict. Rather than dialogue regarding their mismatch and the resultant actions to be taken, the partners might end up in a state of "gridlock." To continue with the husband's fear example, if the couple were gridlocked whenever they discussed the husband's fear, each might feel that the other disrespected their perspective. Gottman and colleagues (1996) reported that an untreated meta-emotion discrepancy between married parents predicted divorce with 80% accuracy.

Similar to classifications of insecure attachment in attachment theory, our clinical experience is that a meta-emotion mismatch (a coaching person combined with a dismissing person, or a coaching person coupled with an out-of-control person) predicts a pattern of turning away from bids, or what has been called the "pursuer–distancer" or the "demand–withdraw" pattern. If both partners are emotion-coaching individuals, we predict that they will turn toward bids at a high rate and have higher levels of emotional expression and intimacy. These are the "volatile" couples described by Gottman (1994). They are better described as "passionate." If they have a 5:1 ratio of positive-to-negative affect during conflict, their relationships will be stable and happy, though they may also have a high need for repair. Yoshimoto (2005) extended meta-emotion research to couple relationships and found that coaching, particularly by husbands, was related to reduced negative affect during conflict and higher levels of marital satisfaction.

Attachment theory has also focused on two main insecure forms of attachment, avoidant and anxious–preoccupied attachment. The avoidant person is cut off from feelings and seems to resemble our emotion-dismissing meta-emotion, while the anxious–preoccupied attachment seems to resemble our out-of-control and overwhelmed meta-emotion. Yoshimoto's (2005) thesis shows that the broader view of meta-emotion mismatches can lead to precise clinical interventions. The interventions begin with the Meta-Emotion Interview, which asks about each partner's history of specific emotions (especially emotions that are problematic in the couple's interaction; e.g., anger), what it was like when others expressed that emotion toward them, and when they have felt that emotion. It is very enlightening for partners to hear each other's answers to these questions. In another specific intervention, we have trained partners in the art of intimate conversation. They practice taking turns as speaker or listener. The speaker expresses a need, and the listener either asks emotion-focused questions (e.g., "What is the full story of that event?"), or makes statements of interest, understanding, and compassion. To reduce defensiveness, the need must be stated as a "positive need," in which one asks for something that the partner can do to shine for one, instead of a negative need, which is what the partner must stop doing.

METHODS FOR ACCOMPLISHING GOAL 4

The world of different emotional experiences and needs is the source of either emotional connection or alienation. In our experience, alienation often involves one person making a bid for emotional connection and the other person either not being aware of the bid or not knowing what to do. No one seems to escape hurt and injury within a relationship. There are two basic couples' mottos that we attempt to build. The first motto is creating a climate of agreement, that is, responding to one's partner with a "Yes, and . . . " attitude instead of a "Yes, but . . . " attitude. That motto helps to maintain and amplify all positive affect emotional command systems (the Explorer, the Jester, the Nest Builder, and the Sensualist). The second motto is "Baby, when you are in pain, the world stops, and I listen and try to understand what you're feeling, and what you need." This motto serves to create attunement, which builds trust, and it also down-regulates all negative affect systems.

In addition to this focus on times of "not being there," we now know that there are continual opportunities on a daily basis for healing through positive emotional connection and bids. We build awareness of these bids, and of typical styles and personal histories of turning away or against. We use the Meta-Emotion Interview to build awareness between partners of their different attitudes, histories, and experiences with expressing and experiencing specific emotions, and their different attitudes toward emotion, introspection, seeking self-insight, self-disclosure, exploration of feelings, and their emotion lexicon. We teach focusing on each person's emotions to those who find it difficult to tune into their proprioceptions by using our "denying your truth" exercise in which a person spends a full minute denying the truth of something they love, then switching to a full minute of telling one's self the truth.

In this part of our therapy, we create mechanisms that allow people to connect during times of emotional need. Emotion coaching is about viewing emotional moments as opportunities for intimacy, asking questions about feelings, putting words to emotional experience, and understanding and validating the partner's emotions before problem solving. A similar blueprint is used in the stress-reducing conversation. Using these skills and awareness during these moments of need, emotion coaching becomes a source of connection rather than alienation. In some ways, this puts the emotion-focused skills of the therapist in the couple's skills repertoire. We teach people how to make their bids and needs explicit (sometimes using the Expressing Needs Card Deck), and how to engage in the art of intimate conversation. We teach them how to ask open-ended questions (using the Open-Ended Questions Card Deck, and the Emotion Coaching Questions Card Deck), and how to make statements that express interest and empathy (Emotion Coaching Statements Card Deck). These card decks jump-start these conversations and make them less challenging and more fun.

REPAIR META-EMOTION MISMATCH

Therapists should expect clients to make mistakes in the process of communication on a regular basis and need help to make repair processes more effective. If both partners are emotion-coaching individuals, they turn toward bids at a high rate and have high levels of emotional expression and intimacy. They will also have a high need for effective repair. They will be the volatile, or passionate, conflict-engaging couples described by Gottman (1994) in *What Predicts Divorce?*. If both partners are emotion-dismissing individuals, then they will bid at a lower rate and subsequently turn toward one another less often. They may also have low levels of emotional expression and intimacy and, as a result, a lower need for effective repair. They are the conflict-avoiding couples described by Gottman (1994). If there is a meta-emotion mismatch between partners, they will need to dialogue using the dreams-within-conflict questions to arrive at a shared culture about emotional expression and responsiveness.

Goal 5. Create and Nurture a Shared Meaning System.

The final part of our sound relationship house theory is the creation of a shared meaning system. All couples build a shared meaning system either intentionally or unintentionally. This is a very important system for creating connection and positive affect. We are a symbol-generating, story-telling species engaged in a search for meaning. The couple's shared meaning system puts Viktor Frankl's (2017) work in the relationship context. We observed the importance of the shared meaning system at several levels of our analysis of couple relationships. The search for shared meaning and a shared story emerged from Buehlman and colleagues' (1992) coding of our Oral History Interview. We also observed the importance of Frankl's work in our analysis of partners' repetitive conflicts in which "hidden agendas" are the symbolic meaning of each person's positions. We now know that compromise is impossible in these conflicts, unless what we call the "dreams within conflict" are addressed (i.e., the stories and wishes behind each person's intractable position). These positions are compromise "deal breakers." The very thought of compromise to both persons feels like giving up the core of who they are and what they most respect about themselves and their life journeys.

The "dreams within conflict" intervention reveals the tip of the iceberg of the shared meaning system. First, in gridlocked, perpetual conflict with hidden agendas, partners need to talk about the story behind their positions, their dreams and wishes, why they are so central to each person, and what their life dreams are on the issue, then to find a way to honor these dreams and adapt to the perpetual dialogue surrounding these recurring conflicts. Master couples discuss the meaning of their positions with one another. Over the years, they reveal the dreams within their positions and talk about them. In our interviews, we find that master couples intentionally build a shared story of their relationships and a sense of purpose and shared meaning in which their own individual existential struggles become merged, in part, into a system of shared meaning.

People create this shared meaning system in several ways:

1. *They build rituals of connection.* First, they create shared meaning simply in the way they move through time together, establish priorities, and build rituals of connection. A "ritual of connection" is a way of turning toward one another that each person can count on. There are formal and informal rituals of connection. For example, dinnertime can include a ritual of everyone talking about their day. Doherty (1997), in his book *The Intentional Family*, reported that most American families do not eat dinner together regularly, and half of those who do have the television on during dinner (which wipes out conversation). There are many areas of informal connection, including weekends, rituals of parting and reunion, what happens when one person gets sick or succeeds or fails at work, and sexual initiation and refusal, to

name a few. Formal rituals include a yearly holiday cycle and what each holiday should mean and why. What should Christmas mean? Or Ramadan, Passover, or Kwanza? What shared beliefs are represented and celebrated in this holiday cycle? Other rites of passage are formal rituals of connection, such as birthdays, anniversaries, confirmations, graduations, weddings, and funerals. Most families take photographs and keep albums of noble and not-so-noble ancestors and relatives. Many families have pictures of these ancestors on their walls and tell stories of their families' legacies. They create a culture of values by giving meaning to the past, and this legacy of values is passed down to the children. In a sense, then, all relationships become cross-cultural experiences in which couples build ways of moving through time together, which then create—through emotional connections—a unique culture of meaning and purpose.

2. *They create shared meaning through supporting life's roles.* Couples create meaning by honoring the roles they play in life. Work careers, their roles as father, mother, son, daughter, sister, brother, friend, philanthropist, leader, and so on, display the variety of roles we all play in life. How do families honor and support these roles? Do people feel appreciated and join in these roles? Do they complement one another's roles? Conversations in the therapist's office can help make these processes intentional.

3. *They create shared meaning through shared life goals.* Partners also create meaning in the goals they set for their families and for themselves. They make plans, problem-solve around these plans, build a home and manage a life together, distribute labor and work together as a team, and express their values as a family. They gather around them a set of friends. They give and receive from their community. They grieve losses together and celebrate successes with their friends and relatives. They sometimes create community, ethical orientation, or spiritual connections and religious or other community affiliations emanating from these shared values. They create a life mission and culture as part of their legacy. They create things together as part of this process. They raise children, they perform music, they write or appear in plays and musicals. They travel and explore together and learn together. They celebrate their triumphs and strivings and suffer together when they are in pain. And even in desperate pain, they still create meaning together. Or, couples may fail to do all these things intentionally.

METHODS FOR ACCOMPLISHING GOAL 5

There are two steps in building the couple's shared meaning system.

Step 1. Make Rituals of Emotional Connection Intentional. The therapist works to make intentional the aspects of the couple's shared meaning system and culture that have hitherto remained implicit or undeveloped.

The first aspect of building the shared meaning system is to nurture the feeling of building something valuable together. One way, as suggested by Doherty (1997), is to help partners intentionally create meaningful rituals of emotional connection (both formal and informal), by answering specifics questions (e.g., "What should moving through time together mean?"). As mentioned, formal rituals include the yearly holiday cycle, birthdays, anniversaries, graduations, weddings, and funerals. Informal rituals of connection involve discussing things such as "What should happen when one person gets sick?" and "What should dinnertime be like at our house?" We have a card deck exercise for building these informal rituals. Defined, formal rituals of connection surround events such as birthdays, rites of passage, and, very importantly, the couple's yearly holiday cycle and its meanings.

Step 2. Make Goals and Values Intentional. What is made intentional here is partners talking about their shared goals, missions, and legacy. Couples often have scrapbooks and photograph albums that contain memorabilia and photographs of noble ancestors, and important places and events in their past. These pictures can be a catalyst for these discussions. Also, partners talk about how they can support each other's central life roles (e.g., mom, dad, son, daughter, brother, sister, friend, worker, leader) and central symbols (e.g., "What is a home?" or "What does love mean?"). Parts of these conversations involve talking about what is sacred to each partner, and what spiritual, moral, or ethical connections they wish to honor in their family. Through these methods, partners are helped to weave together a system of meaning that enriches them both.

Practical Considerations

Gottman method couple therapy is generally not a time-limited program. For couples seeking relationship enhancement, it averages 5–10 sessions; for distressed couples, 15–20 sessions; for couples with serious comorbidities or a recent extramarital affair, it averages 25–50 sessions. For minor domestic violence (not characterological) we have tested an effective approach that comprises 22 two-hour sessions of couple group therapy, with a structured social skills curriculum, and use of self-soothing via the HeartMath biofeedback Emwave device. Termination is handled in our therapy by talking to clients in the first session about phasing out the therapist toward the end of therapy and following couples for 2 years after termination. We discuss our "dental model" of follow-up. Couples can return on an as-needed basis for a checkup and some repair.

The two most common errors our beginning therapists make are as follows:

1. Not understanding the immediate experiential and affective nature of the therapy and trying to follow a prescribed recipe instead of staying with the moment and the couple's affect, that is, ignoring what the couple brings into a session and being inattentive to process. An example of trying to follow a recipe is that some beginning therapists may think they must work on conflict for the first five sessions, when the couple may not need that. Conflict and friendship/intimacy, and shared meaning can be interspersed as needed by the couple. For example, some conflict is generated by failed bids for emotional connection.

2. Not understanding the existential nature of the deepest conflicts, for example, trying to apply the "dreams within conflict" intervention to people's overall life dreams rather than to their position on a specific issue.

We work with individual therapists and may recommend medication as an adjunct to our therapy when a comorbidity is present, provided that there is a flow of information between the individual and the couple therapist. However, in our couple work, we are often doing individual therapy in a couple context. None of us seems to escape childhood without some scars that last forever, and these scars manifest themselves in the anatomy of every regrettable incident we experience. Effective repair requires insight into the stories of these lasting injuries and how they are revealed in our interactions. Couple therapy in Gottman method is contraindicated when there is an ongoing extramarital affair and when there is characterological (as opposed to situational) domestic violence.

Resistance to Change

When we encounter resistance to change, we view it in several ways. Resistance may appear as distrust of the therapist or therapy process based on old attachment injuries; there may also be fear or discomfort with the experience of intimacy. In these cases, the therapist has to work with the resistant partner's fear using empathy, taking care to not pressure that partner to change, but understanding that partner's need to stay in place and voicing feelings without blame or judgment, creating an extremely safe environment, so that the desire for greater connection can grow. Resistance also appears as *a systematic distortion* of one of the fundamental processes of the sound relationship house. That means that encountering client resistance is very central to creating change in therapy.

Let us consider a few of these processes. Most people enjoy discovering more about their partners and being known and enjoy being appreciated and enhancing fondness and admiration. Most people want to make their own needs known and to discover and meet their partners' needs. In these cases, the therapist helps to make these processes easier and attempts to establish them as pillars of the relationship. However, some people have trouble engaging in these processes. For example, people with low self-esteem may have trouble being admired by their partners. Some people may have trouble with having needs, or with knowing how they feel. They are then revealing to the therapist the ways in which they are stuck in this relationship. There is a story and a history behind this resistance. Client resistance is telling the therapist to go deeper into this part of the client's life. We work with people's internal working model of relationships around the very process with which they have trouble. The therapist asks him- or herself: What is their story? In what ways are they stuck in building this part of the sound relationship house? Can that story be rewritten in this relationship? In this view, resistance can be seen by the therapist as "hitting paydirt." It is exactly where the therapy needs to go, and the sound relationship house points the way.

Assessment and Goal Setting

Our therapy begins with a systematic assessment of a couple's relationship strengths and challenges that need improvement, an assessment that directly uses our laboratory's methods.

In our in-session assessment process, we begin with the therapist getting the partners' narrative of what brings them to the therapy. We then administer our Oral History Interview (questions about the history and philosophy of their relationship and their parents' relationships). The coding of that interview is able to predict divorce or stability over a 6-year-period with 94% accuracy (Buehlman et al., 1992). Our therapists are trained to do that coding intuitively. We also tape 10-minute events-of-the-week and 10-minute conflict discussions with physiological monitoring (now obtained directly from video) and ask each partner to rate their emotions during each conversation while watching the conversation video replays. We also conduct individual interview sessions and ask couples to fill out the Relationship Checkup Questionnaires online, which are based on the sound relationship house theory (see below and Gottman, 1999). The information gathered from these sessions and the questionnaire responses inform our assessment. Once the therapist completes a brief checklist, the therapist automatically receives two automated reports, a thorough therapist report with treatment recommendations, and a couple report that can be handed to the couple with only relationship-level information. In a third session, we present this assessment and discuss the treatment goals engendered by it. Once appropriate goals are agreed upon with the couple, intervention can begin.

Following the COVID-19 pandemic, many therapists began doing couple therapy online. A recent innovation of ours called "Gottman Connect" is an online platform that makes it possible for the therapist to easily use time-synchronized assessment (either online or in person) to measure all the variables of the sound relationship house, with an easy-to-do multimethod array of questionnaires, video-recall rating dial data, automated (machine learning) specific affect emotion coding, and heart rate obtained directly from video, valid for all skin tones. Here is how it works for online couple therapy: The therapist sends the clients a free video, teaching them how to complete the assessment. On a special Health Insurance Portability and Accountability (HIPAA)–compliant website, the partners separately fill out the Relationship Checkup Scales before their first therapy session, which takes each partner about 1.5 hours, and they can also be videotaped having two 10-minute conversations (the "events-of-the-week" and "conflict" conversations) along with their video-recall rating dial data, which takes them each another 20 minutes. Their heart rates during the two conversations are detected automatically from the video, so the therapist can later learn if and when each partner was physiologically "flooded" or in flight-or-fight (heart rate > 100 bpm). This conversational assessment can be done by clients at home before the first session, or the two conversations and rating dial data can be acquired in a telesession or live session with the therapist; if the conversations are done in telesession, after being videotaped having the two conversations, one partner can do the rating dial on their phone, computer, or tablet while the therapist does an individual interview with the other partner. After a break in the first session, the therapist then fills out a short checklist. With this streamlined method of assessment, two reports are generated automatically, a therapist report and a couple report for feedback and goal setting with clients. The client report contains only relationship-level information. The therapist report includes individual information and information about comorbidities. Instructions on acquiring all this information are conveyed to the couple and to the therapist with free videos and a simple technical manual. Assessment is then directly linked to specific interventions. Repeated assessments monitor progress in treatment.

The assessment is also accompanied by a suite of computer programs the therapist can choose that links assessment directly with the needed interventions, using a set of 37 video modules we have created called "The Relationship Coach." These modules are also available to couples in an app on their cell phones, with or without a therapist, together with an Assistant program for troubleshooting (*www.gottmanconnect.com*). The Gottman Connect platform also provides six new tools the therapist can choose to acquire: (1) access to a library of tested blueprints and handouts for couples; (2) self-report "emotion check-ins" with clients; (3) tools for building physiological calm in clients; (4) work on comorbidities by identifying triggers in regrettable incidents and by viewing video replays of positive and negative moments of interaction in session; these moments can be identified by the software using rating dial data; (5) 37 Relationship Coach module videos to teach relationship skills as they are applied to issues couples bring to sessions; and (6) teaching that helps make therapeutic changes last between sessions, with an app on a couple's phones that can be used in either crisis mode or homework mode. All of this technology is also available for in-person couple therapy on an iPad used by the therapist. The machine-learning automated emotion coding using SPAFF will eventually lead us to provide more therapeutic tools, based on feedback we get from our 70 beta-test therapists.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability: Minimal Conditions for a Long-Term Relationship

Unlike individual therapy, when two people appear in a therapist's office, there is not necessarily a relationship there to work on. A love relationship is a contract of committed mutual nurturance. The wedding vows allude to these minimal conditions in the marriage contract. Clearly, not everyone should be in a long-term relationship. For some people, it may be better advice for them to have short-term liaisons with people that minimize obligation and responsibility. In the follow-up we have done in our clinical practice, one of the most common issues is when the fundamental beliefs necessary for a long-term relationship are missing. We identify six minimal beliefs as necessary:

1. A belief that commitment is necessary for a long-term relationship to succeed.
2. An agreement of romantic and sexual exclusivity. That assumption may be changing with increased polyamory, but there is not yet systematic research on polyamorous arrangements, except for the qualitative McWhirter and Mattison (1985) study of gay-male relationships and the pre-AIDS epidemic (they found that all gay-male relationships that lasted more than 35 years were polyamorous).
3. An agreement that there will be no secrets, deceptions, or betrayals.
4 An agreement of fairness and care (e.g., when sick, the person will be cared for).
5. An agreement to treat one another with respect and affection.
6. An agreement in principle to try to meet one another's wants and needs.

An old Scottish wedding vow appeals to us: "I plight thee my troth." The word *troth* refers to two things: (1) I give you my truth, that is, there will be no deception, and (2) you have all my worldly possessions, so that I have nothing to offer anyone else: You have it all, you have my whole heart, for my whole life.

Empirical Support

What is the evidence that this theory is useful? We have conducted several randomized clinical trials of our intervention methods. One study comprised programmatic 1- or 2-day friendship-building and conflict-management psychoeducational workshops: Day 1 only versus Day 2 only versus combined Day 1 and Day 2 (called "The Art and Science of Love") versus the combined workshop plus nine sessions of couple therapy, with all compared to a control group (Babcock, Gottman, Ryan, & Gottman, 2013). The 2-day version of the workshop also significantly built upon our trust variable. Shapiro and Gottman (2005) also studied a prevention program for couples expecting a baby. In the latter study, we found that, compared to a control group, with a 2-day workshop, we could reverse the universal drop in relationship satisfaction experienced by nearly 70% of couples transitioning into parenthood plus reduce their hostility and mothers' postpartum depression. In the next study, we added a support group to the workshop and considerably enhanced the already significant magnitude of the treatment effect (Gottman & Gottman, 2007). Finally, we have completed two 5-year randomized clinical trials, both with lower-income couples: one with unmarried couples in poverty expecting a baby, and another with low-income couples experiencing situational domestic violence. The first intervention especially helped couples who were more educated and committed, showing the previously established large treatment effect. Following this study, we designed and tested a new program called "Couples Together Against Violence" (CTAV) by combining this curriculum with focused treatment on preventing escalating conflict, taking breaks, and physiological soothing. The Emwave, a vagal tone biofeedback device made by HeartMath, was used to supplement the intervention. Characterological domestic violence was screened out by a self-report measure we designed. Our intervention was effective even at 18-month follow-up after treatment termination.

We've also conducted years of research on gay-male and lesbian relationships. Levenson and Gottman conducted a 12-year longitudinal study of gay and lesbian couples (Gottman, Levenson, Gross, et al., 2003). Using observational methods, that study revealed that in many ways gay-male and lesbian couples' relationships were stronger than comparable mixed-sex relationships. For example, gay-male and lesbian couples were gentler in presenting issues, less defensive, and had a better sense of shared humor in responding to their partner during conflict discussions. Our mathematical modeling of their interaction confirmed this superiority (Gottman, Levenson, Swanson, et al., 2003). In our large sample Relationship Checkup Study, we found significant and stable differences between same-sex and mixed-sex couples when they presented for couple therapy. Same-sex couples starting couple therapy had stronger friendships than mixed-sex couples but had experienced more past trauma in their primary families. Lesbian couples were less likely and gay-male couples more likely than mixed-sex couples to present with an affair. In an uncontrolled outcome study done in collaboration with the Gay Couples Institute of San Francisco, we reported that Gottman method couple therapy was highly effective in treating both gay and lesbian couples, with a large effect size (Garanzini et al., 2017). Recently, two studies were conducted in Iran, one showing that Gottman method couple therapy was effective compared to a control group (Davoodvandi, Nejad, & Farzad, 2018), and another showing that Gottman method couple therapy was more effective than EFT (Haavasi, Zahra Kaar, & Mohshen Zadeh, 2018).

CASE ILLUSTRATION

"You have my whole heart for my whole life," was definitely not the fact for the Smiths. Jasmine and Bill were Midwesterners, now in their mid-40s, who had been married for two decades. There were no children. He was an executive with a big company; she was a housewife who lived with purpose through board memberships for non-profits. Her upbringing had been full of love and farming chores, while his had been unloving, impoverished, and transient. They'd met in school, fallen in love quickly, and married upon graduating. He'd worked his way up by moving wherever his company needed him. Like the good wife, she followed with no complaints.

But early on there were challenges. His family slashed at her with criticisms, especially his father and two sisters. "Getting a little heavy there, Jasmine? Boy, your legs are big." Jasmine was too polite to object. She'd accost her husband later, "You coward! Why didn't you stand up for me?" He'd mumble defensively and leave the room. This pattern of blame and defensiveness had plagued them for 15 years and led to huge blowouts of rage and hurt. Silence buried their once easy rapport, and sex screeched to a halt. They hardly knew each other now.

In our first virtual meeting, an in-depth assessment was conducted. They took the Relationship Checkup Questionnaires on the Gottman Connect website. Almost every subscore was marked red, indicating that most relationship aspects were challenges, not strengths. Their initial narrative echoed these findings. They hardly nodded to each other now, never touched, and when they fought, escalations shut them down fast. Both hopeless, they filed for divorce. This was their last-ditch effort.

Yet their Oral History Interview revealed a spark. Once, they couldn't get enough of each other. They had loved their conversations and delicious sex life. Most problems they could solve. But this huge one had ruptured the heart of their connection. After an Oral History Interview, Julie Gottman videotaped two conversations they had on (1) their week's events and (2) a current conflict. Then, each partner privately watched video replays and rated their emotions during them. Afterward they took a break while Julie filled out a final checklist, sent all findings to Gottman Connect for analysis, and received detailed reports minutes later.

When the couple returned, Julie handed them a copy of their relationship report and reviewed their findings, using the Sound Relationship House (SRH) as scaffolding for understanding where they needed help. Every level of the SRH needed work. But first, we needed to process the worst of their past regrettable incidents—the big fights they'd had over Bill siding with his family rather than with Jasmine after they had insulted her.

During the first intervention session, we used a tool called "The Aftermath of a Regrettable Incident" as a guide to process a bad fight they had had, which (1) listed the feelings they'd had during the fight, (2) individually narrated a partner's perspective on what happened during the fight without criticism or blame followed by the other partner summarizing and validating, (3) explored triggers that may have intensified the fight, (4) owned responsibility and apologized for their own contributions to the fight, and (5) noted what they could each do to keep similar incidents from occurring again.

Two hours later, they deeply understood what had gone wrong in a 10-year-old terrible fight they'd had. Bill now got at a gut level why Jasmine felt wounded by his family, and felt abandoned when he'd screamed, "Just ignore it!" And she understood why Bill couldn't side with her because he would then have to feel his own anger and shame about how they'd hurt him, too, feelings he'd suppressed for decades.

As to their conflict management patterns, Jasmine was a consummate criticizer. They both got physiologically flooded. Both patterns needed to change. Taking breaks and self-soothing methods were explained, followed by learning "The Gottman–Rapaport Method" for introducing a problem. One partner would speak while the other took notes, summarized, and validated what they heard. Different from active listening, the speaker also had to practice the antidote for criticism and blame by starting with "I feel . . . ," "about . . . " (the situation, not their partner's flaws), and "I need . . . " (a positive need rather than a resentment).

JASMINE: I'm angry and hopeless that I'll get support when your family criticizes me. I need you to really stick up for me.

BILL: (*after summarizing her words*) I don't get why it hurts you, but I understand that you want me to stop their insulting you.

The therapist reassured Bill that the next tool they used would help clarify their positions. They then switched roles. Bill reiterated his confusion over Jasmine's feeling hurt and his wish that she remedy the problem herself.

A "Dan Wile" intervention (Wile, 1988) was also used (revoicing and expanding each partner's communications) to encourage the couple to convey their feelings and needs more graphically. Julie revoiced Jasmine's message by emphasizing her desire for protection, unity with Bill, coming first in his eyes, and reassurance that he still loved her. Bill's revoicing included his hating to see Jasmine hurt, his bewilderment about the right thing to do, and his thinking the safest route was to do nothing.

"Dreams-Within-Conflict," another speaker–listener exercise, followed as the second part of the Conflict Blueprint. The listener would read six questions aloud from a handout and listen to the speaker's answers while delaying any input of their own. Then the partners would switch roles. As the first speaker, Jasmine highlighted her beliefs that a wife should come first and foremost, and given that it was his family insulting her, Bill should speak to them directly rather than her doing so. Growing up, she'd watched her dad always standing up for her mom, and she loved him for it. She also said she'd had an eating disorder as a teenager, and his family's comments about her size were triggering it again. Bill had had no idea.

Bill later described being badly bullied by his parents and siblings. When an adolescent, he also saw how different his family was from others—more slovenly, crass, and lower class—he'd felt ashamed of who he was. He'd worked hard to disguise his heritage while erecting a thick shell to shed their attempts to humiliate him. These survival skills could evaporate if he confronted the poor treatment both he and Jasmine had received. Julie pointed out how difficult it must be to choose between maintaining his shell or sustaining his marriage. By the end, he was clear. He still loved Jasmine; his marriage came first.

Our remaining work employed the Two-Oval Compromise Method (the third part of the Conflict Blueprint) to establish how they would handle Bill's future family visits: Bill would take the lead. Finally, new rituals of connection were established, including affectionate and erotic interactions at a slow and gradual pace. They canceled all plans for divorce proceedings.

CONCLUDING COMMENTS

Our basic research, our theory, and our therapy remain a work in progress. We aim to integrate various approaches to couples—analytic, behavioral, existential, emotionally focused, narrative, and systems—into a theory we find elegant, parsimonious, mathematical, and eminently testable. We aim to improve our ideas over time with both empirical research and clinical experience. We aim to bridge both worlds respectfully. It is our goal to honor those thinkers on whose work we build. It is our goal to generate questions that will stimulate research. It is also our goal to be prescriptive and practical, and to develop tools that will be useful for clinicians.

Couples are endlessly complex. They teach us something new every day through both our research and clinical work. We also are always learning from others like ourselves, who are fascinated by the many turnings in relationships. Thus, we never claim that the methods we have described are the sine qua non of couple intervention. Our work is constantly informed by the mistakes we make, the misunderstandings we commit, and the questions we ask. We are deeply grateful to our research subjects and our clients for their generosity in sharing their worlds with us, and to our clients, for their patience.

SUGGESTIONS FOR FURTHER STUDY

Gottman, J. M. (1999). *The marriage clinic*. New York: Norton.

Gottman, J. M. (2012). *The science of trust*. New York: Norton.

Gottman, J. M., & Gottman, J. S. (2007). *And baby makes three*. New York: Crown.

Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work*. New York: Crown.

Gottman, J. S., & Gottman, J. M. (2015). *10 principles for doing effective couples therapy*. New York: Norton.

REFERENCES

Babcock, J. C., Gottman, J. M., Ryan, K. D., & Gottman, J. S. (2013). A component analysis of a brief psycho-educational couples' workshop: One-year follow-up results. *Journal of Family Therapy, 35,* 252–280.

Bach, G. (1965). *The intimate enemy*. New York: Basic Books.

Blum, D. (2002). *Love at Goon Park: Harry Harlow and the science of affection*. New York: Berkeley.

Bodenmann, G., Pihet, S., & Kayser, K. (2006). The relationship between dyadic coping and marital quality: A 2-year longitudinal study. *Journal of Family Psychology, 20,* 485–493.

Bowlby, J. (1988). *A secure base*. London: Routledge.

Buehlman, K., Gottman, J. M., & Katz, L. (1992). How a couple views their past predicts their future: Predicting divorce from an Oral History Interview. *Journal of Family Psychology, 5,* 295–318.

Damasio, A. (1994). *Descartes' error*. New York: Putnam.

Darwin, C. (1873). *The expression of emotions in man and animals*. New York: BiblioBazaar.

Davidson, R., & Begley, S. (2012). *The emotional life of your brain*. New York: Avery.

Davoodvandi, M., Nejad, S. N., & Farzad, V. (2018). Examining the effectiveness of Gottman couple therapy on improving marital adjustment and couples' intimacy. *Iran Journal of Psychiatry, 13*(2), 136–142.

Doherty, W. (1997). *The intentional family*. Reading, MA: Perseus Books.

Driver, J. L., & Gottman, J. M. (2004). Daily marital interactions and positive affect during marital conflict among newlywed couples. *Family Process, 43*(3), 301-314.

Faulkner, W. (1984). *William Faulkner: Novels 1942–1954: Go Down, Moses/Intruder in the Dust/Requiem for a Nun/A Fable*. New York: Penguin/Putnam.

Frankl, V. E. (2017). *Man's search for meaning*. New York: Beacon Press.

Garanzini, S., Yee, A., Gottman, J., Gottman, J., Cole, C., Preciado, M., & Jasculca, C. (2017). Results of Gottman method couples therapy with gay and lesbian couples. *Journal of Marital and Family Therapy, 43,* 674–684.

Ginott, H. G. (2003). *Between parent and child*. New York: Harmony.

Gottman, J. M. (1994). *What predicts divorce?* Hillsdale, NJ: Erlbaum.

Gottman, J. M. (1999). *The marriage clinic*. New York: Norton.

Gottman, J. M. (2012). *The science of trust*. New York: Norton.

Gottman, J. M. (2015). *Principia Amoris: The natural principles of love*. New York: Taylor & Francis Group.

Gottman, J. M., Coan, J., Carrère, S., & Swanson, C. (1998). Predicting marital happiness and stability from newlywed interactions. *Journal of Marriage and the Family, 60,* 5–22.

Gottman, J. M., & DeClaire, J. (1996). *The heart of parenting: Raising an emotionally intelligent child*. New York: Simon & Schuster.

Gottman, J. M., & DeClaire, J. (2017). *The relationship cure*. New York: Harmony.

Gottman, J. M., & Gottman, J. S. (2007). *And baby makes three*. New York: Crown.

Gottman, J. M., Gottman, J. S., Cole, C., & Preciado, M. (2019). Gay, lesbian, and heterosexual couples about to begin couples therapy: An online assessment of 40,681 couples. *Journal of Marital and Family Therapy, 46,* 218–239.

Gottman, J. M., Katz, L., & Hooven, C. (1996). *Meta-emotion*. Hillsdale, NJ: Erlbaum.

Gottman, J. M., & Levenson, R. (1984). Why marriages fail: Affective and physiological patterns in marital interaction. In J. Masters (Ed.), *Boundary areas in social and developmental psychology* (pp. 110–136). New York: Academic Press.

Gottman, J. M., & Levenson, R. W. (1992). Marital processes predictive of later dissolution: Behavior, physiology and health. *Journal of Personality and Social Psychology, 63*, 221–233.

Gottman, J. M., & Levenson, R. W. (2002). A two-factor model for predicting when a couple will divorce: Exploratory analyses using 14-year longitudinal data. *Family Process, 41,* 83–96.

Gottman, J. M., Levenson, R. W., Gross, J., Fredrickson, B., McCoy, K., Rosenthal, L., . . . Yoshimoto, D. (2003). Correlates of gay and lesbian couples' relationship satisfaction and relationship dissolution. *Journal of Homosexuality, 45,* 23–43.

Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships: Mathematical modeling of conflict interactions. *Journal of Homosexuality, 45,* 65–91.

Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work.* New York: Crown.

Gottman, J. S. (Ed.). (2004). *The marriage clinic casebook.* New York: Norton.

Gottman, J. S., & Gottman, J. M. (2015). *10 principles for doing effective couples therapy.* New York: Norton.

Harlow. H. (1974). *Learning to love.* New York: Aronson.

Havaasi, N., Zahra Kaar, Z., & Mohsen Zadeh, F. (2018). Compare the efficacy of emotion focused therapy and Gottman couple therapy method in marital burnout and changing conflict resolution styles. *Journal of Fundamentals of Mental Health, 20,* 15–25.

Jacobson, N. S., Schmaling, K., & Holtzworth-Munroe, A. (1987). Component analysis of behavioral marital therapy: 2-year follow-up and prediction of relapse. *Journal of Marital and Family Therapy, 13,* 187–195.

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy* (2nd ed.). New York: Brunner/Routledge.

Katz, L. F., & Gottman, J. M. (1993). Patterns of marital conflict predict children's internalizing and externalizing behaviors. *Developmental Psychology, 29,* 940–950.

Keicolt-Glaser, J. K., Bane, C., Glaser, R., & Malarkey, W. B. (2003). Love, marriage, and divorce: Newlyweds stress hormones foreshadow relationship changes. *Journal of Consulting and Clinical Psychology, 71,* 176–188.

Kuhn, R., Bradbury, T. N., Nussbeck, F. W., & Bodenmann, G. (2018). The power of listening: Lending an ear to the partner during dyadic coping conversations. *Journal of Family Psychology, 32*(6), 762–772.

LeDoux, J. (1996). *The emotional brain.* New York: Simon & Schuster.

Leudke, A., Peluso, P. R., Diaz, P., Baker. A., & Freund, R. (2017). An analysis of the first session: Measuring affect in the therapeutic relationship to predict dropout and return. *Journal of Counseling and Development, 95,* 125–135.

Levenson, R. W., Carstensen, L. L., & Gottman, J. M. (1993). Long-term marriage: Age, gender and satisfaction. *Psychology and Aging, 8,* 301–313.

Levenson, R. W., & Gottman, J.M., (1983). Marital interaction: Physiological linkage and affective exchange, *Journal of Personality and Social Psychology, 45*, 587–597.

McWhirter, D. P., & Mattison, A. M. (1985). *The male couple.* New York: Prentice Hall.

Milner, P. M. (1991). Brain-stimulation reward: A review. *Canadian Journal of Psychology/Revue canadienne de psychologie, 45*(1), 1–36.

Newcomb, M. D., & Bentler, P. M. (1980). Assessment of personality and demographic aspects of cohabitation and marital success. *Journal of Personality Assessment, 44,* 11–24.

Northrup, C., Schwartz, P., & Witte, J. (2013). *The normal bar.* New York: Harmony.

Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions.* New York: Oxford University Press.

Raush, H. L., Barry, W. A., Hertel, R. K., & Swain, M. A. (1974). *Communication conflict and marriage.* Oxford, UK: Jossey-Bass.

Robinson, E. A., & Price, M. G. (1980). Pleasurable behavior in marital interaction: An observational study. *Journal of Consulting and Clinical Psychology, 48,* 117–118.

Shapiro, A. F., & Gottman, J. M. (2005). Effects on marriage of a psychocommunicative-educational intervention with couples undergoing the transition to parenthood, evaluation at 1-year post intervention. *Journal of Family Communication, 5,* 1–24.

Siegel, D. (1999). *The developing mind.* New York: Guilford Press.

Ushakova, J. N. (1997). Russian psychology. *European Psychologist, 2,* 97–101.

Wile, D. B. (1988). *After the honeymoon.* New York: Wiley.

Wilson, K. R., Havighurst, S. S., & Harley, A. E. (2012). Tuning in to kids: An effectiveness trial of a parenting program targeting emotion socialization of preschoolers. *Journal of Family Psychology, 26,* 56–65.

Yoshimoto, D. K. (2005). Marital meta-emotion: Emotion coaching and dyadic interaction. *Dissertation Abstracts International B: The Sciences and Engineering, 66*(6), 3448.

PART III

APPLICATIONS OF COUPLE THERAPY

SPECIFIC RELATIONAL ISSUES AND POPULATIONS

CHAPTER 17

Couple Therapy for Partner Aggression

Norman B. Epstein, Jaslean J. LaTaillade, and Carol A. Werlinich

BACKGROUND

It has long been known that physical and psychological aggression occur frequently in couple relationships, but couples' private lives were treated as a taboo topic until social scientists began to investigate severe negative effects of intimate partner violence (IPV). Initially the focus was on physical aggression, due to its more obvious damage, and the Centers for Disease Control and Prevention (CDC) reported 1,295 deaths nationwide in 2010 as a result of IPV—10% of all homicides (Spivak et al., 2014). Physical partner aggression has been documented around the world (Devries et al., 2013), and rates among female and male same-sex couples are similar to those among mixed-sex couples (e.g., Rolle, Giardina, Caldarera, Gerino, & Brustia, 2018). Aggression often begins at young ages, with 9% of high school students reporting physical violence by a boyfriend or girlfriend (Spivak et al., 2014).

The rate of physical aggression by women is comparable to that of men when the full range of severity is examined, and clinic samples show similar rates of injury to men (15%) and women (12%) (Jose & O'Leary, 2009). However, men are more likely to use severe violence (Afifi et al., 2009; Archer, 2000), and women experience greater psychological (e.g., depression, trauma symptoms) and physical (injury, death) consequences (Ulloa & Hammett, 2016). Even with lower physical severity (e.g., pushing, slapping), aggression has negative effects on victims' psychological well-being (e.g., Ahmadabadi et al., 2020) and undermines relationships, destroying partners' sense of safety and satisfaction, especially for women (Ackerman & Field, 2011). Partner aggression is more common among couples who seek therapy, with on average half reporting physical aggression and 76–95% reporting psychological aggression by males and 69–95% psychological aggression by females (Jose & O'Leary, 2009).

As advocates for victims drew attention to battering of women in the 1970s, cases were addressed by providing shelters and using courts to mandate treatment for male perpetrators (O'Leary, 2008). Mental health practitioners commonly assumed that couples who sought therapy for relationship problems were unlikely to be engaging in physical violence. When therapists asked couples in joint interviews about violence or relied on open-ended inquiries about problems that led them to seek assistance, they deprived individuals of safe conditions for revealing victimization. Also, as noted by O'Leary (2008), in the 1980s, some writers still suggested that women played a role in maintaining abusive relationships and were blameworthy for not leaving violent male partners. Feminist writers focused on protecting victimized women with resources such as free legal aid and shelters. They also warned that due to gender-based power imbalances and patriarchal values, couple therapy was dangerous for victimized women (Yllo, 1993).

Forms of Partner Aggression and Who Engages in Them

Research has revealed different forms of partner aggression and who engages in which. Johnson (2006) differentiated four patterns of physical violence among mixed-sex couples: "patriarchal terrorism" or "battering" (primarily by a male against a female to exercise control), "violent resistance" (by a female to counteract male violence), "mutual violent control" (bilateral violence for control), and "situational" or "common" couple violence (bilateral, mild to moderate, expressing unhappiness). Comparable incidence of physical aggression among gay, lesbian, and bisexual couples (Rolle et al., 2018) underscores that partner aggression is not restricted to mixed-sex couples.

Forms of psychological aggression (e.g., hostile withdrawal, denigration of the partner, domination and threats of violence, and restriction of the partner's freedom) commonly precede and co-occur with physical aggression. Rates of psychological aggression among community couples are approximately 75% (Jose & O'Leary, 2009). Negative effects on victims' psychological and physical well-being, as well as relationship satisfaction and stability, can be similar to or even more severe than some forms of physical aggression (Jose & O'Leary, 2009). Psychological aggression and mild to moderate physical aggression are characteristic of common couple violence.

Gender-Specific Treatment Groups

Based on concerns about couple therapy, the major intervention for partner aggression historically has been gender-specific treatment groups. Men's groups focus on increasing perpetrators' willingness to take responsibility for their behavior, modifying beliefs that support violence, and improving anger management (O'Leary, 2008). Groups for victimized women focus on improving mental and physical health, and increasing resources to maintain safety (Poleshuck et al., 2018). However, groups for perpetrators have shown limited effectiveness, with high recidivism (Gilchrist, Munoz, & Easton, 2015; Murphy & Eckhardt, 2005). Because group interventions do not focus on perpetrators' interactions with the partners they have victimized, it is not surprising that changes may not generalize to those relationships. However, components of those programs designed to reduce denial of responsibility and increase motivation to change have been incorporated into couple therapy approaches.

Development of Models for Conjoint Couple Therapy for Partner Aggression

Because gender-specific group treatments do not directly address couple dyadic aggression patterns, researchers and clinicians have investigated the potential for intervening with couples conjointly to replace aggression with constructive ways of interacting with one's partner. To date, a few couple therapies for partner aggression have been evaluated empirically. The two major approaches have been cognitive-behavioral couple therapy (CBCT) and solution-focused couple therapy (SFCT), both of which are structured, relatively time-limited, and quickly interrupt aggressive patterns while developing constructive alternative behavior. Other models have potential but as yet have not been evaluated in clinical trials. For example, emotion-focused therapy (EFT) intervenes with couples' negative interaction cycles, including insecure attachment responses that trigger aggression (Slootmaeckers & Migerode, 2019).

Most programs that have been evaluated empirically have been cognitive-behavioral. They focus on modifying empirically supported risk factors for partner aggression: (1) reliance on "overlearned" aggressive behavior to express unhappiness and influence a partner, (2) deficits in communication and problem-solving skills, (3) negative cognitions that fuel anger and justify aggression, (4) poor regulation of negative emotions, and (5) difficulties in coping with life stresses (LaTaillade, Epstein, & Werlinich, 2006). Heyman and Neidig's (1997) Physical Aggression Couples Treatment (PACT) program is a multicouple group CBCT intervention with components on psychoeducation (regarding stress and anger), anger control, strategies for challenging one's anger-eliciting thoughts, communication skills, collaborative decision making, positive sexual interaction, coping with jealousy, and mutual social support.

Stith, McCollum, and Rosen's (2011) couple therapy for partner aggression uses a solution-focused brief therapy approach that emphasizes couples' existing strengths for resolving their issues, with other interventions added when there is danger of current violence. The therapist encourages partners to formulate a picture of their relationship without the problem, identify successes they already have had, and devise feasible solutions (see also Chapter 11, "Solution-Focused Couple Therapy," in this volume, by Franklin, Zhang, Bolton, & Yates). Initial sessions are structured, with the first six conducted separately for each partner in the single-couple version or for separate groups of men and women in the group version. They include psychoeducation about forms of aggression, safety planning, mindfulness self-soothing skills, and time-out skills. In subsequent sessions, the therapist asks clients questions that lead them to discover new ways to control aggression.

The Conjoint Cognitive-Behavioral Treatment for Partner Aggression program (CCBTPA), developed by our research group (LaTaillade et al., 2006) and highlighted in this chapter, involves a protocol delivered to individual couples experiencing psychological and mild to moderate physical aggression, over ten 90-minute weekly sessions (or an alternative schedule of twenty 45-minute sessions). It addresses risk factors (e.g., beliefs that justify aggression, communication skills deficits, poor emotion regulation), targeting behavioral, cognitive, and affective components of aggression. It includes psychoeducation (forms of aggression, risk factors, effects of aggression on individuals and their relationship); anger management; cognitive interventions to modify attributions and standards that contribute to anger and aggression; communication and problem-solving training; and strategies to help couples recover from past trauma associated with aggression.

CORE UNDERSTANDINGS ABOUT PARTNER AGGRESSION

Risk Factors for Partner Aggression

Conjoint treatments should target reduction of risk factors for aggressive behavior, while enhancing protective factors that lessen the risk of aggression. The following are major identified risk factors for psychological aggression and mild to moderate physical aggression.

Relationship Dissatisfaction

Relationship dissatisfaction is associated with partner aggression concurrently and longitudinally for perpetrators and victims (Ackerman & Field, 2011), and across individualistic and collectivist cultures (Mallory et al., 2016). It is both a risk for development of partner aggression and a result of it.

Relationship Conflict

Couples need to resolve conflicts constructively to meet the individuals' needs and accomplish basic functions of a close relationship (e.g., physical and financial security, companionship, intimacy). Some couples respond to conflict with dysfunctional patterns such as aggression, avoidance, or withdrawal. Many types of behavior exhibited by couples during conflict discussions (e.g., contempt, belittling, blaming, threatening, domineering, demanding, hostile voice tone, verbal or nonverbal withdrawal) tend to fall within the scope of psychological and mild to moderate physical partner aggression. However, due to the commonplace nature of psychological aggression, in our experience, some couples accept them as typical ways of responding to conflict or lack more constructive skills for resolving issues.

Deficits in Constructive Problem-Solving and Relationship-Repair Skills

Couples that engage in aggression commonly lack skills for interrupting negative exchanges, solving problems, and redirecting themselves toward positive interactions (Epstein & Baucom, 2002). Gottman (1999) describes repair responses that can stop negative escalation, such as disclosure of feelings ("I'm feeling sad"), taking responsibility or apologizing ("My reactions were too extreme. Sorry") and moving toward compromise ("I think your point of view makes sense").

Learned Aggressive Responses to Conflict

There is evidence, including across individualistic and collectivist cultures (Mallory et al., 2016), that perpetrators of partner aggression have histories of exposure to family-of-origin violence, and researchers have identified factors (e.g., poor emotion regulation, a learned expectancy that aggression is effective in controlling others) that mediate between exposure to family aggression and individuals' aggression in their couple relationships (Ehrensaft, 2009). Identification of aggression in families of origin can help clients view it as learned and not inevitable.

Cognitive Risk Factors

In addition to learned expectancies regarding the instrumental value of aggression, individuals who are aggressive tend to hold beliefs that condone aggression (e.g., Robertson & Murachver, 2009). They also commonly make negative attributions that their partners have hostile intentions, which they may use to justify retaliation against partners (Makin-Byrd & Azar, 2011).

Gender Roles, Culture, and Power in the Couple Relationship

Feminist theory posits that males' violence against female partners establishes power. Men report a higher likelihood of using physical aggression when they perceive themselves to be powerless with their partners and feel out of control (Stets, 1988). Both husbands and wives in physically aggressive relationships feel more controlled by their partners (Robertson & Murachver, 2011). Control is associated with partner aggression in both individualistic and collectivist cultures (Mallory et al., 2016).

Being a member of a racial or ethnic minority is associated with greater risk of partner aggression, with greater risk found for Black/African American populations (Capaldi, Knoble, Shortt, & Kim, 2012). Cumulative experiences of racism toward Black, Indigenous, and other people of color are associated with worse physical and mental health, as well as relationship distress and partner aggression (Lavner, Barton, Bryant, & Beach, 2018). These stressors tax a couple's resources, increase conflict, and elicit negative coping, such as aggression (e.g., LaTaillade, 2006; Lavner et al., 2018). Stress involving discrimination toward same-sex and sexual minority couples also may contribute to partner aggression (Stephenson & Finneran, 2017). Individuals who also are members of another minority (e.g., racial) may face stress from multiple sources of discrimination that intersect to shape experiences of partner aggression (Greene, Boyd-Franklin, & Spivey, 2013).

Psychopathology

A variety of psychiatric disorders (e.g., anxiety, depressive, bipolar, posttraumatic stress, psychotic, substance use, personality disorders) are more common in male and female perpetrators of physical partner aggression than among nonviolent individuals (Crane, Hawes, Devine, & Easton, 2014). The strong association between alcohol and drug use and partner aggression across cultures (Mallory et al., 2016; O'Farrell & Fals-Stewart, 2006) necessitates that clinicians assess substance use that precedes incidents of aggression. Some characteristics that do not constitute diagnosable psychopathology also are risk factors for partner aggression (e.g., insecure attachment; Dutton & White, 2012).

Enhancement of Relationship Strengths in Couple Therapy for Partner Aggression

Couple interventions for partner aggression also create opportunities to increase positive qualities of a relationship such as trust, security, and intimacy. Reducing negative processes does not guarantee satisfaction with one's relationship (Epstein & Baucom, 2002). Improving partners' abilities to share thoughts and emotions constructively, increasing empathy for each other's vulnerabilities, solving problems collaboratively, and increasing pleasurable activities contribute to a warmer, more intimate relationship. Building strategies to maintain those skills after therapy provides the couple a resilience factor for counteracting stresses they face in the future.

THE PRACTICE OF COUPLE THERAPY FOR PARTNER AGGRESSION

The Structure of the Therapy Process

A number of couple therapy models (cognitive-behavioral, behavioral, solution-focused, emotion-focused) have been demonstrated to be appropriate for couples experiencing psychological and mild to moderate physical partner aggression, as long as they address the risk factors we described and provide structure to block destructive interactions and maintain safety.

Although therapy models vary in assumptions regarding causes of relationship problems and processes needed to reduce negative interactions, all models appear to emphasize to varying degrees some common treatment objectives: (1) increasing partners' awareness of aggressive behavior and its negative effects on individual well-being and relationship quality; (2) decreasing aggressive behaviors; (3) increasing emotion regulation; (4) increasing skills for communication and conflict management; (5) reducing effects of gender role, family-of-origin, and cultural beliefs on the use of aggression; and (6) strengthening the overall relationship. Although all of these objectives are consistent with the cognitive-behavioral framework that we emphasize, they can be implemented within a variety of systemic treatment models while maintaining core assumptions, language, techniques, and processes of each model. Consequently, in the following description of our CCBTPA protocol, we comment on aspects of other models that are relevant for treating partner aggression.

Our model includes psychoeducation about aggressive behavior and its negative consequences, increasing use of anger management skills during conflicts, reducing negative cognitions that fuel anger and aggressive behavior, improving communication and problem-solving skills, helping the couple recover from any broken trust (e.g., past aggressive behavior), and increasing mutual support and shared positive activities. The following is a description of the protocol that we evaluated in our outcome research, in which the number of therapy sessions devoted to each treatment component was standardized for all couples. However, we believe that in clinical practice it is appropriate to evaluate the amount of each treatment component that each couple needs, and to tailor the length of therapy to each couple's characteristics.

Initially, the protocol was delivered in 10 weekly, 90-minute sessions. The rationale for double-length sessions was our assumption that couples experiencing aggression need intensive intervention at least initially to disrupt negative couple interaction patterns. However, feedback from clients and therapists indicated that the protocol could be implemented in 45-minute sessions, so couples were offered a choice of either ten 90-minute sessions or twenty 45-minute sessions. In general practice, therapy lasts a few months on average, but it depends on the severity and chronicity of the couple's problems. Sessions typically are held weekly and are tapered as the couple reaches goals and approaches termination. The option exists for booster sessions to maintain gains. Toward the end of each session, therapist and couple collaborate in devising homework that the couple will enact before the next session, based on what was covered during the session (e.g., practicing expressive and listening skills).

Sessions can be conducted by either a single therapist or a co-therapist team. Advantages of co-therapy include safety if one or both members of a couple have emotion regulation difficulties (although severe emotion dysregulation is a contraindication for using couple therapy), and opportunities for each therapist to coach one of the partners as they interact and practice skills.

All sessions are conjoint because the emphasis is on modifying partners' responses to each other. A couple can participate if partners are also involved in concurrent individual therapy, and at any point the therapist can refer a partner for individual therapy if personal issues are interfering with the ability to participate in couple therapy. At the beginning of each session, the therapist asks about possible incidents of aggression since the prior session. If there were instances of more than mild physical aggression, the therapist conducts a supplemental crisis management session focused on preventing further violence. If more than two crisis management sessions are needed, the therapist informs the partners that couple therapy cannot continue, for safety purposes. They are offered referrals for individual therapy and are eligible for further couple therapy when they demonstrate improved ability to manage anger. We strongly believe that couple therapists need to maintain clear limits on what is acceptable behavior in order for conjoint therapy to proceed. Furthermore, we recommend very judicious use of telehealth with cases of even mild aggression, with close monitoring of tension and aggression in the couple's daily life.

The Role of the Therapist

The therapist's role involves education, consultation, and skills building. Psychoeducation is provided regarding forms of partner aggression, negative effects on individuals and couples, risk factors the couple can work on to reduce, anger and its management, and skills for communication and conflict management. Psychoeducation is an aspect of cognitive restructuring to motivate partners to change their behavior and understand rationales for interventions. It draws on principles of motivational interviewing (Arkowitz, Miller, & Rollnick, 2017). Feedback to couples regarding both their strengths and areas for improvement, suggestions for harnessing their strengths to solve problems, and emphasis on how partners have the freedom and responsibility to pursue change can facilitate improvement (Cordova, Warren, & Gee, 2001).

The therapist also makes the consultant role explicit. The first session includes identification of treatment goals, and aside from the emphasis on reducing aggressive behavior and improving conflict management, partners are encouraged to identify goals that they would like to work toward to have a more satisfying relationship. Couples typically have a variety of other concerns and goals (e.g., childrearing, job stresses that affect their relationship).

Although establishing therapeutic alliances with both partners is always important in couple therapy, it can be especially sensitive in dealing with partner aggression. Even when individuals hold beliefs that aggression toward a partner is justified, they often are aware that it commonly is viewed as socially undesirable and may be defensive when a therapist focuses on their actions. When one partner engages in unilateral aggression, that individual may view the therapist's discussion of partner aggression as blaming the person. Thus, it is crucial that the therapist convey respect and empathy for both partners, even while emphasizing negative effects of poor conflict management and each person's responsibility for their own behavior. We emphasize a strengths-based perspective: The therapist helps partners identify positive qualities that attracted them initially, recall their dreams for a fulfilling relationship, and realize the importance of committing themselves to reducing interactions that create unhappiness and distance (drawing on motivational interviewing). A danger lies in the therapist's appearing to judge and condemn individuals *as people* rather than focusing on their counterproductive *actions*. Because partner aggression is so value-laden, we avoid use of "loaded" terms such as "abuse." The therapist identifies forms of aggression and reasons why those behaviors must be changed but appeals to the partners' desires for mutual caring and respect in their relationship.

The therapist is moderately directive, as it is assumed that the couple has ingrained patterns that must be interrupted and replaced by constructive ones. Although the therapist at times sits back and observes interactions in order to identify targets for intervention, the therapist does not allow negative responses to continue. Polite but firm interruptions are used to draw partners' attention to a negative sequence, engage them in monitoring and reporting their cognitions and emotions, and coach them in modifying negative responses. When partners express volatile emotions, the therapist blocks aggressive behavior but empathically encourages each individual to express feelings in a moderated manner, using communication skills. The message is that strong emotions indicate that an issue is important to the person and needs attention, but thoughts and emotions must be expressed constructively so that meaningful dialogue can occur.

Given that the therapist serves as a consultant and teacher, there are times when the individual partners speak more with the therapist than with each other. However, because a core goal is modifying partners' interactions with each other, it is crucial that the therapist guide them in speaking with each other often. It is appropriate for the therapist to self-disclose to some degree in giving psychoeducational examples; for example, in discussing monitoring of one's anger arousal cues, physical cues may be disclosed associated with the therapist's own anger.

Self-of-Therapist Issues

Therapists need to be aware of their own experiences with anger and aggression that may influence reactions to clients and how they conduct therapy. Experiences in the therapist's family of origin and personal couple relationships can affect comfort in interacting with volatile couples, ability to establish positive therapeutic alliances with both partners, and so forth. This does not involve therapist self-disclosure regarding personal issues, but it may call for consultation with a colleague, supervisor, or personal therapist.

Assessment and Treatment Planning

To increase detection of partner aggression, clinicians need to use structured, multimethod assessment procedures (see also Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin). We recommend that clients contacting a therapist by phone or an online platform regarding couple therapy for a variety of problems receive a brief initial screening for areas that concern them, as well as for substance use, psychological aggression, and physical aggression. The therapist cannot be sure that the caller has privacy, as an aggressive partner might be present, even if the caller states otherwise. Callers who report victimization with severe physical aggression are given referrals for gender-specific treatment, shelters, and similar resources because conjoint treatment is contraindicated. Those who report an absence of severe physical aggression and that their partner is willing to participate in therapy are invited to schedule an in-person, conjoint assessment session, including further assessment for aggression.

Extra caution must be exercised when assessing for partner aggression when clinicians are providing telehealth services. Evans, Lindauer, and Farrell (2020) noted that requests for IPV assistance decreased during the recent COVID-19 pandemic, due to victims' inability to meet privately in person with a professional. Evans and colleagues (2020) and Wrape and McGinn (2018) detailed telehealth assessment and intervention practices that couple therapists can use to minimize risk to victims of partner aggression, including (1) present screening questions regarding partner aggression as standard practice with all clients; (2) request that partners use separate personal devices for individual assessment sessions whenever possible, and use earphones so they can respond privately to the therapist's questions; (3) decide on a nonverbal signal (verbal cue for phone conversations) that will inform the therapist that the individual is experiencing fear of their partner; (4) advise victimized individuals to delete their Internet browsing and phone text message records of contacts with the clinician and other support resources; (5) conduct brief, weekly check-in screenings with partners for recent aggressive incidents; and (6) have referral information regarding national and local IPV resources available to send victims. Furthermore, therapists should apply methods described in this chapter to monitor and intervene promptly with cues of escalating anger and aggression during conjoint telehealth sessions, such as coaching partners in noticing and communicating about cues of their own anger arousal, practicing self-soothing strategies, collaborating in the use of "time-outs" to cool down, and committing to avoid retaliation toward a partner after the session. Therapists also should identify the location(s) of the partners during each session, in case there is a need to send them emergency services.

The therapist takes care during the in-person or telehealth joint interview when inquiring about aggression to protect any victim from retaliation regarding disclosures. In order to establish a positive alliance with both partners, the therapist begins with a generic couple assessment interview (Epstein & Baucom, 2002). It begins with demographic information, each partner's goals for therapy, a concise relationship history (e.g., how the partners met, what attracted them, life events that influenced their relationship in a positive or negative way), and an overview of the CCBTPA treatment approach by the therapist. We recommend construction of a genogram with the couple, representing at least three generations of their families: their own, their parents', and their children's. The therapist asks about relations among family members, and data can help the therapist and couple understand how partners developed response patterns, including aggressive behavior. The therapist also makes initial observations of the couple's behavioral patterns (e.g., criticism, interruptions).

The therapist then conducts a separate interview with each partner, so each can feel safe discussing sensitive issues. We describe the purpose as a way to get to know each partner. The therapist emphasizes that information each person shares will be kept confidential, although the clinician does not want them to share secrets (e.g., an ongoing affair). Before each partner's interview, the therapist administers and examines screening questionnaires. We use the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) that ask about physical aggression, psychological aggression, and sexual coercion, with subscales regarding perpetration by oneself and by one's partner. The CTS2 also includes a subscale assessing constructive negotiation. We also use the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999) for assessment of psychological aggression, as it includes subscales assessing denigration, hostile withdrawal, dominance/intimidation, and restrictive engulfment, using the same format as the CTS2. Agreement between partners' self-reports of aggressive behavior tends to be low to moderate (Rathus & Feindler, 2004), with individuals reporting lower enactment than their partners report about them. Although both perspectives may be biased, we place greater weight on a person's report about the partner's use of aggression.

It also is advisable to administer a measure of relationship satisfaction. Funk and Rogge's (2007) four-item version of their Couples Satisfaction Index (CSI-4) is a psychometrically sound instrument that assesses global relationship satisfaction. Measures such as the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982) and the Timeline Followback (TLFB; Agrawal, Sobell, & Sobell, 2009) can be used to screen for psychopathology and substance use, respectively.

The individual assessment interview with each partner begins with the person's physical health, psychological functioning, medications, quality of family-of-origin relationships, educational and employment history, romantic relationship history, current social support network, and quality of the current couple relationship. If an individual's CTS2 or MMEA responses indicate victimization or perpetration, the therapist asks about frequencies and severity of specific actions, a victim's fear of the perpetrator, and any barriers to the victim's taking actions to be safe. The therapist asks for details regarding conditions leading to aggressive incidents, the sequence of behaviors between partners, whether this sequence is typical, any injuries, what events followed the aggression (e.g., further threats by the aggressor, apologies by either partner), and whether the police or others were summoned (Rathus & Feindler, 2004).

If the individual interview indicates that the person has been injured, is in danger, or the perpetrator uses substances, posing a risk for violence, the therapist discusses options for seeking safety (e.g., crisis phone numbers, shelter locations, abuser counseling services, legal system resources for protection orders). The therapist emphasizes not sharing the disclosure of violence with the partner but informing the couple during the subsequent joint meeting that individual therapy will be the option offered to them at this point, to improve their abilities to manage conflict before couple therapy can occur. If both partners report mild to moderate physical aggression (no injury), any psychological aggression, comfort with conjoint treatment, and a desire to improve their relationship, the couple is offered couple therapy.

Each partner's culture, language, race and ethnicity, sexual orientation, and gender identity are also assessed in the individual interview. These social identities intersect with one another to form individuals' unique experience of the world, particularly as it relates to their beliefs and perceptions regarding couple relationships and, for partners who identify as a member of one or more minority groups, experiences of marginalization and oppression (Crenshaw, 1991). Attending to stressors associated with being a member of a racial, sexual, gender, and/or ethnic-minority group that may be associated with engaging in partner aggression (e.g., experiences of discrimination, internalized stigma; LaTaillade et al., 2006; Stephenson & Finneran, 2017), as well as the influence of intersecting identities on relationship power dynamics, can help therapists understand how and why partners use aggression to respond to conflict in their intimate relationships. It is also important that therapists learn about and convey respect for each couple's cultural beliefs and traditions. Therapists also must be aware of their own values regarding control and aggression, and how those influence responses to clients. We take a firm stand against partner aggression, striving to engage aggressive partners in working toward a relationship in which each person is treated with care and respect. For example, if one or both partners believe that there should be a strong leader in the family, we emphasize that a strong leader also can be benevolent and caring.

It also is important to focus on relationship strengths during the assessment. Because many therapy models construe aggressive behavior as being due to personal deficits, it is crucial to identify a couple's strengths and build on them too. Many aggressive individuals have strong emotional bonds with their partners that can be used to build motivation to stop aggression and nurture a mutually caring relationship. Aspects of motivational interviewing that focus on improving the relationship are useful in treating relationship distress and aggression (Cordova et al., 2001; McCollum, Stith, Miller, & Ratcliffe, 2011).

Treatment Planning When Assessment Reveals Issues in Individual Functioning

Because partner aggression commonly co-occurs with problems in individual functioning (e.g., substance abuse, attachment insecurity), it is important to consider whether referrals for concurrent individual therapy for one or both partners may be necessary. O'Farrell and Fals-Stewart's (2006) treatment program has demonstrated the potential for combining couple interventions with traditional individual cognitive-behavioral treatment for substance abuse, but our CCBTPA protocol involves referrals for individual treatment of alcohol and drug abuse, due to the risk that it poses for partner aggression. In cases in which a couple has experienced severe physical aggression resulting in injury, conjoint couple therapy is contraindicated (see Chapter 25 on alcohol problems, in this volume, by McCrady, Epstein, & Holzhauer). To maintain positive alliances with both partners, when a therapist refers one member for individual therapy, it should be portrayed as a contribution that individual can make to improving couple interactions, and contributions that the other partner can also make (e.g., practicing communication skills) are identified.

Goal Setting

Many of the goals that partners have in seeking treatment (e.g., resolving financial stress, parenting issues, conflicts regarding relationships with in-laws) may have no direct link to partner aggression, although the couple's inability to resolve issues often is due at least in part to the aggressive process in their relationship. We draw the partners' attention to the distinction between the content of their issues and the interpersonal process of poor anger management and aggressive interaction that occurs regarding those issues. The therapist surveys the issues for which the partners seek change, guiding the couple in prioritizing the goals and emphasizing that an overarching goal must be the development of less aggressive and more constructive ways of interacting as a couple when working toward the other goals. The therapist asks the couple to consider priorities in terms of which goals seem most likely to improve their relationship, as well as which seem most feasible. When partners rank their goals differently, the therapist guides them in creating a list that balances their desires, promoting the advantages of egalitarian decision making. Commonly, a couple has a shared sense of hopelessness regarding change due to chronic discord, so we suggest beginning work on a smaller goal that has good potential for change, to increase their expectancies that they can make changes. The therapist emphasizes that all sessions will include taking steps toward managing anger and conflict.

Therapists commonly encounter couples whose members have different agendas for the relationship, including one being committed to improving it while the other is ambivalent. As noted earlier, during the initial individual assessment individuals may reveal that they have been victimized and either are ambivalent about staying with the partner or would prefer to leave. Whereas some perpetrators also may prefer to end the relationship, others may be fearful of losing their partner and may have used aggression to restrict the partner's freedom to leave. When a victim expresses a goal of escaping and a perpetrator wants them to stay together, in order to protect the victim, the therapist shifts toward individual work with the two partners rather than couple therapy. Based on ethical issues regarding conflict of interest and confidentiality, it is most appropriate for the therapist to refer them to other clinicians for that work, providing them a rationale (e.g., that at present they appear to have difficulty communicating and do not seem ready for the intensity of couple sessions). However, if an individual who has been victimized with psychological and mild to moderate physical aggression feels safe but is ambivalent about the relationship, we offer the approach that we use more generically with distressed couples—suggesting a trial period of couple therapy that might improve their relationship, after which they can decide whether they want to work on the relationship further (see also Chapter 21 on divorce, in this volume, by Lebow).

Throughout goal setting, the therapist explicitly brings expertise to the process. Because skills for emotion regulation, counteracting cognitions that fuel anger and conflict, communication, and problem solving are key components of treatment, the therapist provides psychoeducation for spending time on them to help achieve the partners' goals. The therapist conveys a value that aggression is an inappropriate way of expressing unhappiness, influencing one's partner, or reacting to stress, so a goal of therapy will be to replace aggressive patterns with constructive ones.

Process and Technical Aspects

Cognitive, affective, and behavioral factors all contribute to individuals' psychological and physical aggression toward their partners. Individuals are more likely to behave aggressively when they think in particular ways (e.g., believe that a partner who treats one poorly deserves to be punished), have difficulty regulating emotions such as anger and anxiety, and rely on aggressive behavior to vent upset feelings and try to influence the partner. It is not necessary to know details about historical roots of an individual's current aggression in order to begin interventions, but knowledge of personal history can help the therapist and couple anticipate possible barriers to change. For example, an individual who grew up in a family in which members competed in aggressive verbal debates can be anticipated to revert at times to this "default" pattern during disagreements. Instead of blaming that partner, the couple can announce that they have "slipped into debate mode" and agree to take a break and restart their discussion.

Although therapists intervene with each individual's cognitions, emotional responses, and behavior, CCBTPA emphasizes dyadic processes in which partners engage in interactions that involve aggression (Epstein & Baucom, 2002). For example, as one partner withdraws, the other partner may behave aggressively in an attempt to block the partner's withdrawal, or both partners may escalate aggression in an attempt to "win" arguments. Such dyadic processes can lead to aggressive behavior rapidly and seemingly automatically. Therapists commonly observe rapid changes in a couple's interactions and emotional intensity during a session, in which the partners shift from discussing a topic calmly to mutual emotional agitation and verbal aggression, after one person's statement, facial expression, or voice tone is interpreted negatively by the other person. Couples remain at risk of further escalation of aggression because they often are not aware of the rapid shift in their interaction until the therapist points it out. Interventions that capture such dyadic patterns help the couple become "participant-observers" who take the role of therapist for themselves and interrupt exchanges that become aggressive. Victims are never blamed for a partner's aggression, but they are asked to take responsibility for avoiding escalation of conflict.

We begin with descriptions of interventions to modify behavioral, cognitive, and affective components of partner aggression (e.g., for detailed procedures, see Epstein & Baucom, 2002, and Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom et al.). We then describe the sequence in which they are applied within our CCBTPA protocol, as well as decision making regarding sequencing tailored to couples' needs.

Interventions to Modify Behavior

TIME-OUT

When couples have difficulty with escalation of anger and aggressive behavior, therapists can guide them in using a "time-out," an agreement to interrupt negative interaction and distance from each other temporarily, in order to use emotion regulation strategies and plan a more constructive approach to talking with the partner. The therapist must help the couple differentiate between a collaborative time-out and withdrawal used by some individuals to avoid discussions. Therapists need to emphasize both partners' support of the other's use of a "cooling-off period" and showing each other that it is safe to return to discuss issues further, by interacting calmly with each other and explicitly stating that they are feeling calm and are dedicated to avoiding further aggression.

COMMUNICATION SKILLS TRAINING

This intervention involves educating and coaching couples in the use of expressive and empathic listening skills to self-disclose; to learn more about each other's thoughts, emotions, and needs; and to demonstrate to each other that they care enough to listen well (see Chapter 3, in this volume, by Baucom et al.). It is applied in CCBTPA to replace aggressive interactions with communication patterns that help couples resolve conflicts constructively. The psychoeducation counteracts individuals' prior learning in their families of origin and broader cultural background that aggression is an acceptable way of expressing upset feelings and influencing their partner. The structure of taking turns in the expresser and listener roles helps counteract escalation of emotional arousal (i.e., it facilitates emotion regulation) and aggressive behavior. Because some partners come from cultural backgrounds that emphasize indirect contextual communication, and therefore "sit on" their upset feelings until they eventually vent anger aggressively, CCBTPA emphasizes more open communication but requires that therapists be sensitive to those individuals' reluctance to express themselves directly.

PROBLEM-SOLVING SKILLS TRAINING

Once the couple has demonstrated ability to use expressive and listening skills to regulate negative emotion and aggressive behavior, the therapist can use similar psychoeducation and coaching methods to teach them problem-solving skills to resolve conflicts. Problem-solving steps (see Baucom et al., Chapter 3, in this volume) counteract the adversarial and coercive interactions involved in partner aggression, as they emphasize collaboration and respect for each other's ideas and preferences. Psychoeducation regarding benefits of teamwork also counteracts beliefs associated with partner aggression (e.g., "If someone tries to control you, push back hard").

INCREASING POSITIVE BEHAVIOR ADDRESSING CORE NEEDS

Because relationship distress is a risk for partner aggression, interventions that result in partners treating each other in pleasing ways can contribute to less aggression. The therapist can draw on the couple's history of activities they enjoyed to guide them in planning to enact behaviors that create new positive experiences (for detailed intervention methods, see Baucom et al., Chapter 3, in this volume; Epstein & Baucom, 2002).

Interventions to Modify Cognition

We already have described how some behavioral interventions (e.g., psychoeducation about problem-solving skills) can influence partners' cognitions. However, some interventions directly focus on partners' cognitions about each other and their relationship. The following interventions are used specifically to reduce risk factors for partner aggression.

INCREASING AWARENESS OF AUTOMATIC THOUGHTS ASSOCIATED WITH ANGER AND AGGRESSION

The therapist begins with psychoeducation regarding characteristics of stream-of-consciousness, automatic thoughts that flash through individuals' minds and how particular ones can trigger strong anger and aggressive behavior. The therapist then guides partners in developing skills for noticing their own automatic thoughts when they begin to feel angry or behave aggressively with each other (e.g., "She's going to regret treating me that way! I'll get even with her!"). In addition to increasing awareness of automatic thoughts that fuel anger and aggression, interventions can tap the individual's underlying beliefs (e.g., "The way to stop someone from treating you poorly is to inflict emotional or physical pain, instilling fear"). Being aware of the power that aggressive thoughts have on emotions and actions toward one's partner is a prerequisite for actively counteracting them.

DEVELOPING SKILLS FOR REPLACING NEGATIVE THOUGHTS WITH MORE CONSTRUCTIVE ONES

When tracking their negative thoughts associated with anger and aggression, partners are coached in considering alternative thoughts about the situation that are neutral or even positive:

> "The way he rolled his eyes at me instead of answering my question really pissed me off; it was so disrespectful. I feel like screaming at him. However, I want him to be aware of how he behaves toward me and take responsibility for treating me in a caring way. If I scream at him, he'll probably withdraw more. If I calm myself, look him in the eyes and tell him how his behavior comes across, it will be a lot harder for him to ignore how I feel."

Homework can include keeping logs of situations and automatic thoughts associated with anger and aggressive behavior toward one's partner, as well as attempts to devise more constructive alternative ways of thinking.

MODIFYING ASSUMPTIONS AND STANDARDS THAT SUPPORT AGGRESSION

Because aggression sometimes results in the targeted person's compliance with the aggressor's desires, perpetrators commonly assume that aggression has benefits. Cognitive interventions designed to disrupt such assumptions involve psychoeducation regarding costs of aggression for the well-being of individual partners and their relationship (e.g., the victim loses trust and affection for the perpetrator) that outweigh the payoffs, as well as feedback from the victim that confirms those drawbacks. Communication training that demonstrates to an aggressor that the partner is warmer when aggression is avoided also can modify assumptions regarding benefits of aggression. Similarly, when aggression is maintained by personal standards that justify it (e.g., that to retaliate against a partner is justified), the therapist can increase the person's awareness of disadvantages of that standard and guide the aggressor in experimenting with nonaggressive ways of influencing the partner (e.g., constructive self-expression).

As noted previously, modifying individuals' standards that support inappropriate aggression often requires psychoeducation about forms of psychological and physical aggression and their effects on recipients. Some couples are surprised to learn that behaviors described on the MMEA are classified as psychological aggression (e.g., tried to stop the other person from seeing certain friends or family members; put their face right in front of the other person's face to make a point more forcefully; refused to have any discussion of a problem; called the other person a loser, failure, or similar term). It is crucial that the therapist be sensitive in challenging culturally based standards that justify forms of aggressive behavior and avoid shaming the person by respectfully presenting a rationale for minimizing aggressive behavior.

Interventions for Emotion Regulation

Anger is commonly considered to be the typical emotion leading to partner aggression, but anxiety associated with attachment insecurity also is a significant contributor. Consequently, therapists need to include interventions focused on increasing partners' abilities to notice and moderate a variety of strong negative emotional responses to each other. It also is important to include interventions to increase experiences of positive emotion, or else low relationship satisfaction may remain a risk for conflict and aggression. Goals of emotion regulation interventions include (1) noticing one's emotional states and their associations with specific events in the relationship that elicit them, (2) using self-talk to prepare oneself for stressful interactions with one's partner and cope constructively (e.g., initiating a time-out), (3) using self-soothing strategies to reduce arousal, and (4) using constructive communication and problem solving to discuss reasons for upset feelings and to plan needed changes.

Regarding tracking emotional responses and eliciting events, the therapist can use psychoeducation to increase understanding of cognitive, affective, physiological, and behavioral components of an emotion such as anger—the information that emotions provide about one's needs. The therapist then can coach partners in tracking and evaluating the appropriateness of their automatic thoughts associated with emotional responses. This coaching tends to slow automatic and rapid escalation of negative emotion. Couple therapists can use Meichenbaum's (1985) stress inoculation approach to teach partners how to use self-talk to counteract escalation of anger and aggressive behavior. Each partner is guided in constructing self-statements to practice and use during stressful interactions, to prepare for and cope with a stressor (e.g., "She is likely to criticize me for being late. I can relax my body, take slow deep breaths to stay calm, avoid getting into a debate that would escalate, and use communication skills we have learned to show I understand how she sees the situation"). The therapist can explore "hot thoughts" that elicit anger during interactions with the partner (e.g., "What a jerk! I'm not going to let him treat me that way!"), emphasizing that a focus on inflammatory thoughts will only increase negative emotions and behavior.

In addition to encouraging a couple to collaborate in using time-outs to interrupt emotional escalation, the therapist can coach them in identifying self-soothing strategies that work for them. The therapist can describe a variety of self-soothing activities, some of which can be used to calm oneself before engaging with one's partner (e.g., listening to music, exercising, taking a warm shower), and others that can be used to reduce one's emotional arousal while interacting with the partner (progressive muscle relaxation; slow, deep breathing; mindfulness exercises; calming self-talk). The couple also can be coached during sessions in practicing muscle relaxation and breathing exercises while discussing stressful topics. Throughout anger management training, the therapist coaches the couple in using expressive, listening, and problem-solving skills, to increase their confidence that their partner will understand their feelings, and that they can cooperate with each other to resolve issues.

Sequencing Interventions

Overall, the interventions focused on behavior, cognition, and emotion are used with all couples in an integrative way, based on a core assumption that the three domains mutually influence each other. In the 10-session CCBTPA protocol (LaTaillade et al., 2006), the sequence was designed to be implemented as follows:

- *Session 1.* The therapist explores the couple's reasons for seeking therapy, presents an overview of the program, takes a relationship history, coaches the couple in devising goals for therapy (the primary goal being an aggression-free relationship), and guides them in completing a no-aggression contract. The therapist provides psychoeducation regarding use of time-outs to deescalate conflict. For homework, the couple is asked to review their goals, revise them if they wish, and experiment with using time-outs during the coming week as needed.

- *Session 2.* The therapist and couple review (and refine as needed) the therapy goals, and the therapist explains how development of skills will help them achieve those goals. The therapist presents psychoeducation (including handouts) about content and process of couple interactions, especially effects of constructive versus destructive ways of expressing thoughts and emotions. Examples from the couple's relationship are used to illustrate influences of behavioral responses, cognitions, and emotion on relationship quality. The therapist teaches and coaches the couple regarding anger management strategies in addition to time-outs. For homework, the couple is to practice anger management strategies.

- *Sessions 3 and 4.* Expressive and listening skills are taught and practiced. The therapist gives the partners handouts on communication guidelines and models the skills, and the couple practices them with benign topics, with coaching from the therapist. The couple progresses to discussing more significant topics, so they are able to communicate about moderate to severe conflict. The therapist provides psychoeducation about the role of cognitions in anger arousal and aggression and coaches the couple in identifying their cognitions, including negative attributions about each other's intentions, positive expectancies about consequences of aggression, and beliefs regarding dominance in relationships.

They are instructed in using cognitive restructuring techniques to challenge negative cognitions. Homework includes additional practice of communication skills, as well as continued use of anger management techniques.

- *Sessions 5–7.* The couple is taught problem-solving skills for resolving conflict without aggression and is coached in combining communication and problem-solving skills with increasingly conflictual topics in their relationship. These sessions also include exploration of gender roles, cultural influences, family history, and belief systems influencing partner aggression. Memories of aggressive behavior and its negative consequences in their families of origin may be used to increase their motivation to use more constructive conflict management now. Work continues on identifying and modifying negative cognitions that interfere with problem solving (e.g., "I'm too angry to be nice to my partner right now!"). Homework focuses on further practice of skills used in sessions.

- *Sessions 8–10.* The therapist focuses on applying skills for communication, problem solving, testing cognitions, and regulating emotional responses toward recovery from past traumatic experiences and broken trust, as well as building a positive bond. It is emphasized that partners need to be patient as they work for the common good of the relationship. For example, the therapist encourages a formerly aggressive partner to be supportive when the other partner continues to exhibit symptoms (e.g., anxiety, lack of trust, defensive withdrawal). The therapist emphasizes the value of acknowledging one's past mistakes, taking responsibility for past hurtful actions, avoiding blaming one's partner for problems, expressing willingness to work on the relationship within reason despite past hurts, and committing to personal change.

In clinical practice, therapists can vary the sequence and duration of interventions based on each couple's needs. For example, if partners have strong resentment toward each other from the past and believe retaliation is justified, the therapist may need to focus on these emotions and beliefs early in therapy, or they may not be motivated to use constructive time-outs and communication skills. Throughout treatment, the therapist monitors the level of aggression and is prepared to set limits with couples who violate the no-aggression agreement. If a couple vents anger while practicing communication, the therapist would focus on interventions for cognitions and emotion regulation difficulties that are interfering with their ability to interact constructively.

Similarly, if partners exhibit resistance to interventions, the therapist can explore factors that may be interfering with the therapeutic alliance and consider modifying the treatment plan somewhat to address client concerns without abandoning core treatment goals. In our experience, common sources of resistance to interventions involve partners' experiences of vulnerability and potential loss of power. For example, if a man vents anger toward his female partner because he attributes her disagreements about money management to disrespect, he may interpret a therapist's focus on collaborative problem solving as siding with his partner. The therapist first reiterates that the goal is to support partners and help them reduce conflict, and if either perceives the therapist as biased, they want to understand anything they did that contributed to it. The therapist then explores past behavior by the female that the male interpreted as respectful, which actions now seem disrespectful, whether he can think of alternative reasons for her behavior other than disrespect, and how he would prefer they discuss issues. The therapist works to repair the "rupture" of the therapeutic alliance, explore the man's negative attributions about his partner, and focus the couple on constructive interaction.

Potential Strategic Errors in Couple Therapy for Partner Aggression

After the therapist establishes an agreement with a couple at the outset of treatment that aggressive behavior must cease, it is crucial that the therapist hold the couple to it. Failing to address aggressive incidents between sessions sends the couple a message that the therapist's expectations of them are fluid. The process that led to the aggressive incident and ways to avoid further incidents should be the top priority of that session. It is also important to not allow couples to engage in aggression during sessions more than briefly; otherwise, they may perceive implicit acceptance of aggression. Another error a therapist may make when treating partner aggression is underestimating danger when one or both partners appear to be "nice, reasonable people," in spite of evidence that they have engaged in aggression. Finally, partners should not be pressured to disclose complaints about each other during sessions when the therapist has little idea of how such disclosures will be interpreted, or whether an individual might retaliate later.

Decisions Regarding Termination

Consistent with our approach that emphasizes collaboration between the therapist and couple, the appropriate time for termination of therapy is decided jointly by the three parties. That decision is based on judgments that the goals for therapy have been reached, including the cessation of partner aggression and development of skills for managing conflict. "Good" termination is based on both partners being comfortable with how they are relating, especially when they presented with a power differential in which one of them tended to control the other.

MECHANISMS OF CHANGE

In our CCBTPA model for treating partner aggression, couples' awareness of processes that influence aggression, as well as knowledge of techniques to modify them, is considered an important form of insight. Psychoeducation is used to sensitize partners to such information, motivate them to make changes, and teach them new ways of relating to each other. In addition, partners' insight into intergenerational patterns of aggression and related family dynamics can help motivate them to change ("The buck stops here—no more violence in this family!").

The learning and repeated practice of skills for communicating and resolving conflicts constitute a core curative mechanism. The skills are taught in a didactic manner, with considerable coaching as the couple's behaviors are shaped. Homework between sessions is considered very important in consolidating changes in the couple's daily life. Improving partners' awareness of their emotions and abilities to regulate strong negative emotions is another important curative factor. Our approach to anger management is based on an assumption that awareness of one's emotional responses is a prerequisite to regulating them. Psychoeducation and other cognitive interventions counteract individuals' beliefs that they have a "short fuse" (that their anger erupts with no warning). Therapists coach partners in attending to bodily cues of arousal as signals to implement emotion regulation techniques.

Because working with partner aggression commonly involves exposure to poorly regulated emotions, it is important that therapists be comfortable with others' anger expression, which at times may be directed toward the therapist as well. Therapists play a key role as a model of balance between awareness of one's feelings and constructive expression of them. Consequently, therapists need to be aware of their own anger triggers and ways of managing anger responses.

In addition to specific interventions targeting aggression, the relationship between therapist and partners is also a significant curative factor. It involves tactfully but directly confronting partners with their negative responses and attempting to motivate them to experiment with alternative ways of responding, which initially may make them feel vulnerable. A strong therapeutic relationship can help overcome partners' reluctance to change. The structure of CCBTPA and a moderate degree of therapist directiveness does not preclude therapist warmth, empathy, and positive regard for partners.

Mechanisms of change for ameliorating partner aggression and relationship distress do not ensure changes that promote growth and partners' mutual fulfillment in the relationship. Consequently, interventions for improving communication skills, building support for each other's vulnerabilities, collaborating in solving problems and achieving life goals, and increasing emotional connection are core paths pursued to increase relationship satisfaction.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

For Whom Is Couple Therapy for Partner Aggression Appropriate?

With ongoing assessment and safety precautions, couple therapy for partner aggression is appropriate for those who experience any psychological aggression and mild to moderate physical aggression, but no severe violence. The research we summarize below indicates that forms of structured couple therapy that interrupt aggressive patterns and quickly shift couples toward more constructive interactions can be safe and effective. If one or both partners experience psychopathology severe enough to compromise functioning in therapy and at home, including untreated substance abuse, conjoint treatment is contraindicated unless individual treatment can be conducted concurrently. Our treatment approach for aggression necessitates that partners have the capacities to understand their interaction patterns, develop greater empathy for each other's feelings and needs, monitor their own cognitions and emotional responses, and maintain sufficient motivation to replace aggressive behavior with constructive skills. It is our experience that these capacities are "common factors" that influence the effectiveness of any couple therapy for partner aggression, although there is a need for research on such treatment outcome moderators.

Ethical Considerations

We concur with others regarding ethical issues raised by conjoint therapy with individuals who have a history of inflicting injury on a partner, and we take precautions to protect clients from harm. Given evidence that couples with psychological aggression and mild to moderate physical aggression can be treated safely, we believe it can be a constructive ethical decision to identify such couples and treat their negative interaction patterns directly. Simply refusing to treat partners together and referring them for separate individual therapies will not deter many of them from continuing to live together and manage conflict poorly.

Evaluating Outcomes in Clinical Practice

In clinical practice, therapists can evaluate the outcome of their work with individual couples through the partners' and their own perceptions of attainment of the initial therapy goals, partners' scores on validated questionnaires assessing targets of therapy, and observations of couple interactions during sessions. The same cautions that are applicable to assessing partner aggression at intake (to protect individuals from retaliation for disclosing socially undesirable behavior) apply in collecting information about therapy outcomes.

Regarding client and therapist ratings of therapy goal attainment, clinicians can present a couple a list of the goals identified at the outset of therapy and ask each of them to rate the degree to which each goal has been achieved, on a Likert-type scale (e.g., from 0 = *not at all* to 10 = *completely*), and the therapist also can use the same scales to rate goal attainment. The therapist then can engage the couple in a three-way discussion of the degree to which they consider the goal attainment sufficient to plan for termination versus a number of additional sessions before reevaluating progress. Discrepancies between the outcome ratings by the two partners and therapist are discussed, and a joint decision is made regarding appropriateness of termination.

The therapist can separate the partners and ask them to complete the same questionnaires assessing current partner aggression (CTS2 and MMEA) that they completed during the pretherapy assessment. Aggressive episodes can be monitored throughout therapy with a brief form that each partner completes before each session, reporting any instances in which aggressive behavior occurred during the past week. Improvement in relationship satisfaction can be evaluated by readministering Funk and Rogge's (2007) CSI-4. The posttherapy assessment also should include a separate interview with each person, focused on occurrences of aggression and the individual's level of fear of the partner. The individual interviews also present an opportunity to explore changes in each person's cognitions that were targeted as risk factors for aggressive behavior, such as beliefs about appropriateness of aggression and negative attributions regarding a partner's motives. Finally, it also is important to evaluate partners' communication and problem-solving skills by observing their interactions during sessions and in a pretermination session as the therapist asks them to discuss topics that still elicit some conflict.

Empirical Support for Conjoint Treatment of Partner Aggression

A number of conjoint approaches have been developed that target partner aggression and also are designed to enhance the overall quality of the relationship. The following is a summary of outcome research on those approaches. All programs are intended for psychological aggression and mild to moderate physical aggression but no battering.

PACT (Heyman & Neidig, 1997) is a cognitive-behavioral approach delivered to groups of couples. Its goals include educating couples about relationship violence and alternatives to partner aggression; increasing personal responsibility for aggressive behavior; and eliminating partner aggression, as well as increasing positive couple interaction and relationship satisfaction through anger management and conflict resolution skill training. PACT was compared to gender-specific treatment (O'Leary, Heyman, & Neidig, 1999). Husbands and wives reported increased marital adjustment, and scores of husbands decreased on measures of psychological and physical aggression, increased on taking responsibility for their violence, and decreased on blaming their wives for the husbands' violence. Wives reported decreases in self-blame and taking responsibility for their husbands' aggression. One-year follow-up results indicated decreases in husbands' psychological and physical aggression, and both husbands and wives reported increased marital satisfaction. Contrary to the investigators' hypothesis that PACT would be more effective than gender-specific treatment, the two treatments were equally effective in reducing the frequency of partner aggression.

Stith, Rosen, McCollum, and Thomsen (2004) evaluated multicouple and individual-couple versions of their integrative approach that emphasizes solution-focused therapy. Their model is based on the premise that clients bring both personal resources and problems to therapy that can be used to generate solutions to the problems. Therapists engage clients in identifying specific outcomes they desire and steps they can take toward achieving those goals (Stith et al., 2011). They emphasize the couple's goals (e.g., enjoying daily life together free of tension) rather than imposing standard goals other than eliminating aggression. As in our CCBTPA approach, their protocol includes detailed safety procedures, no-violence contracts, psychoeducation regarding forms of partner aggression and their negative consequences, use of mutually agreed-upon time-outs to deescalate conflict, and some training in mindfulness meditation to improve emotion regulation. Communication and conflict resolution skills practice are used with couples who need more than couple-generated identification of nonaggressive ways of interacting. In their outcome study, Stith and colleagues (2004) found that males in the multicouple condition, but not the individual-couple condition, had a lower partner aggression recidivism rate than those in a no-treatment control group at 6 months posttreatment. At 2 years posttreatment, males in the individual-couple condition had lower recidivism than those in the no-treatment group, and there was a trend for men in the multicouple group to have lower recidivism than those in no-treatment. In addition, those in the multicouple condition, but not in individual-couple therapy or no-treatment, exhibited increased marital satisfaction and lowered aggression, and male partners in only the multicouple group demonstrated lowered acceptance of wife battering at the end of therapy. Stith and colleagues (2011) reported that both women and men who completed the program, in both formats, exhibited reduced physical aggression. Furthermore, Stith and colleagues (2020) describe case studies of their model applied in Columbia, Iran, and Finland, with cultural adaptations that demonstrated its helpfulness.

In our clinical trial evaluating the CCBTPA protocol, clinic couples presenting with psychological aggression and mild to moderate physical aggression were assigned randomly to CCBTPA or treatment as usual—a variety of family systems models (e.g., emotion-focused, structural, strategic, solution-focused, narrative) intended to make partners aware of problematic patterns in their relationship and assist them in developing constructive nonaggressive patterns. In both treatment conditions, no-violence contracts were written and enforced, and treatment focused on reducing systemic patterns that contributed to partner aggression. Both treatment conditions resulted in increased relationship satisfaction, decreased psychological partner aggression, decreased physical aggression (assault and injury) by males and a trend toward such a decrease by females, reduced negative attributions about one's partner, increased overall trust in the partner, and decreased anxiety and increased positive moods prior to engaging in a conflict resolution discussion with one's partner (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011; Kahn, Epstein, & Kivlighan, 2015; LaTaillade et al., 2006). The CCBTPA treatment also produced significant decreases in observed negative communication by both males and females, whereas treatment as usual did not change negative communication patterns. Neither treatment condition led to an increase in positive communication.

Finally, case studies (e.g., Slootmaeckers & Migerode, 2019) provide evidence that EFT (Greenberg & Goldman, 2008) can help reduce common couple aggression. Controlled outcome studies are needed to determine the extent to which EFT also reduces risk factors for aggression (e.g., beliefs justifying retaliation, emotion regulation difficulties, overlearned aggressive behavior).

CASE ILLUSTRATION

Carla (age 33), an Anglo woman, and Santiago (age 35) a Latino man, are a cisgender, mixed-sex couple married for 8 years. It is the first marriage for both partners, and they have had no previous individual or couple therapy. Carla initially consulted their priest about her anxiety associated with marital conflict. She described frequent arguments but stated that there had been only one incident of mild physical aggression. When the priest met with the couple, they emphasized their desire to restore peace and closeness they experienced in the past, and concern about effects of their conflict on their children: sons Santiago Jr., age 7, and Gabriel, age 6, and daughter Maria, age 4. The sons were aggressive with each other, and Santiago Jr. shoved his sister when frustrated with her. The priest recommended that they consult a marital therapist. Carla contacted a therapist by phone, who conducted a screening interview, including questions about psychological and physical aggression, to provide an initial evaluation of safety for couple therapy. Carla said she felt safe with Santiago and viewed the physical altercation as an outlier.

The therapist was an Anglo female, age 40, with training in couple therapy, especially CBCT, and experience working with culturally diverse clients. Because she had limited fluency in Spanish, she noted to Carla that she wanted to check with Santiago during their first joint session whether he would be comfortable with a therapist who could not shift into Spanish if needed to clarify material.

Assessment

Joint Couple Assessment Interview

After the couple signed the consent form, the therapist asked them to describe their goals for therapy. Both focused on reducing arguments and restoring closeness. The therapist described how aspects of the CCBTPA approach could help reach those goals. She described her role in guiding them, and the importance of them taking responsibility for contributing to changes in their couple patterns. She then asked them for a brief history of their relationship: how they met, what attracted them, how they developed a committed relationship, and events that influenced their relationship in either a positive or negative way. They described how they had met at work. Carla was attracted by Santiago's confidence, attentiveness, passion regarding things he believes in, intelligence, and good looks. Santiago was attracted by Carla's being a solid person with clear goals, intelligence, family orientation, respect for him, and beauty. Although he likes her reserved manner more than his family's volatility, he is upset when she withdraws when they argue.

Both partners described a positive atmosphere early in their relationship but a trend toward conflict. Carla said she was taken aback when her husband was sarcastic, and Santiago stated that he perceived Carla as uninterested in his point of view. This pattern escalated recently when they argued after Santiago said he was upset about the amount of time Carla was spending with coworkers after work. Carla defended her right to have a life besides childrearing and her job, and said Santiago was selfish. This led to mutual shouting, her walking away, his pursuing her, her pushing him away, his grabbing her arm, and her slapping his face. Maria began to cry, and Santiago Jr. yelled for them to stop. Santiago left the house for an hour, and when he returned, they spoke about how concerned they were about exposing their children to stress and violence. During the interview, the therapist observed that they interrupted each other often and blamed each other for escalation of arguments.

Questionnaires

The therapist asked the couple to complete questionnaires in separate rooms: a demographic data form, the CSI-4, the BSI, and the CTS2. On the CTS2, both reported only recent and infrequent mild physical aggression (grabbing, pushing) and chronic moderate bilateral verbal aggression, consistent with their interview reports. On the CSI-4, both partners indicated moderate unhappiness, and neither partner reported significant psychopathology on the BSI. The therapist concluded that it seemed safe to move ahead with couple therapy, depending on what each partner revealed during their individual interview. She concluded the session by meeting with the couple jointly, emphasizing the importance of the partners' committing themselves to creating a safe environment for each person to express thoughts and feelings.

Interviews with Individual Partners

Carla reported that she was raised in a Midwestern city in a family that included her father, mother, older brother, and younger sister. Both parents worked throughout her childhood. Her family's culture (Catholic and relatively conservative politically) and the local community were low in diversity. Family members did not share feelings much. Although her father expressed caring, he could be gruff. Carla knew she could ask her parents for help with practical problems but not regarding relationships and feelings. She sometimes witnessed her parents arguing after they had been drinking cocktails, which on a few occasions ended with mutual pushing and her mother leaving the room crying. No one in the family talked about those incidents. Santiago's expressions of anger triggered vivid memories of the turmoil between her parents, anxiety, and a strong urge to withdraw.

Carla attended school through college in the Midwest, then moved to New York City at age 23 for a job at a major bank. She dated a moderate amount before meeting Santiago. She reported no history of psychological problems, and her BSI responses were consistent with her interview. Other than taking maternity leave for each child's birth, she worked full-time.

Santiago was raised in Puerto Rico, with a large extended family. He moved to New York City at age 18 with his parents, maternal grandparents, and two brothers (one older and one younger), for his father's job opportunity. He completed college in the New York area, then obtained a job at a local bank, where he is still employed. Carla was the first woman he dated who he believed would be a good life partner. Santiago's parents, siblings, and extended family members were bilingual in Spanish and English, although the primary language spoken at home was Spanish. His mother held part-time jobs but focused on parenting. Family relationships were highly valued in their community. Traditional gender roles common in Puerto Rican culture existed in his family and neighborhood, and his parents raised their sons to be strong leaders in their own homes and workplace. The boys were competitive and vied for their parents' approval. Everyone in the family was emotionally expressive, but both parents emphasized *respeto*, courteous expression of esteem for others. Santiago stated that when Carla debated with him, it felt like competition with his brothers.

During the individual interviews, the therapist administered the TLFB and asked each person about alcohol and drug use by self and partner, as well as any association between substance use and aggression. She also asked whether the individual felt safe living with the partner and participating in couple therapy. Carla and Santiago reported only occasional social drinking, with no related aggression, and both said they felt safe but were alarmed at the recent escalation. The therapist believed it was safe to move ahead with joint therapy, with regular monitoring of aggression and interruption of couple sessions in the event of any violence.

Goal Setting

In the next joint session, the therapist reviewed the couple's presenting concerns and goals (reduce arguments, restore intimacy), which Carla and Santiago validated. She emphasized the couple's strengths and asked them to describe how they could draw on the strengths to improve their conflict management. Next, she asked them to describe patterns when they argue. They agreed that they both try to make points, do not listen much to the other person, become defensive if criticized, and feel frustrated at "not being heard." The argument deteriorates into name-calling. Even though Santiago is bilingual, they converse only in English. When they argue and speak rapidly, he feels stressed by trying to keep up with Carla verbally and feels "outdebated" by her. She becomes exasperated and refuses to keep talking. The more he pursues her to counter her criticism, the more she wants to escape.

The therapist gave the partners handouts describing forms of psychological and physical aggression, as well as negative effects those behaviors have on the recipient and relationship. Carla stated that watching her parents argue convinced her that those types of behavior are unacceptable, but that Santiago seems to believe it is fine to be aggressive with his brothers or her. Santiago became upset, and the therapist interrupted to ask what he was thinking and feeling. He replied that he was angry that Carla portrayed him negatively. The therapist emphasized that her goal was to understand and support both partners and help them become less adversarial, and she could see how quickly tension builds between them. She proposed that arguments could be reduced by changing specific negative behaviors, cognitions, and emotional responses. Examples were slowing discussions so Santiago would feel less stressed by Carla's fluency, taking turns being the expresser or an empathic listener, engaging in self-soothing procedures, each of them examining the appropriateness of their own upsetting cognitions (e.g., attributions that your partner does not respect you), and using time-outs to interrupt escalation. The goal of increasing intimacy also was translated into specific behavioral changes they could make.

Foci and Process of Couple Therapy Sessions

After goal setting, the therapist used the remainder of the first therapy session to introduce the time-out process. For homework, the therapist asked the couple to review their goals and identify any additional goals to add. She also asked them to try using a time-out in the event that an argument began. The next session began with a check-in regarding the homework. The couple had added a goal of developing better ways to cope with the different communication patterns in their families. They also used a time-out, initiated by Carla when Santiago became frustrated by her correcting his childrearing approach. The therapist praised them for their effort and reiterated that working on communication skills would make it easier to discuss challenging topics. She then provided psychoeducation about anger management (e.g., progressive muscle relaxation; slow, deep breathing; self-instruction in not responding to provocation) and guided the couple in practicing relaxation exercises during the session and in selecting anger management techniques to try as homework.

In the next session, Santiago and Carla reported that they had used a time-out twice to interrupt tense exchanges and were able to self-soothe sufficiently to meet again to discuss the issues. However, both still tended to interrupt, resulting in frustration. The therapist introduced the rationale and methods of expressive and empathic listening skills. She gave the partners handouts describing the communication guidelines, modeled them, and coached the couple in practicing them, beginning with benign topics. She also reviewed anger management techniques that they had agreed to practice and coached on using them while discussing relationship issues. The therapist recommended that they continue practicing anger management and communication skills in subsequent sessions and at home. The couple committed to further practice, although their busy life resulted in uneven compliance. The therapist expressed empathy for their stressful schedules but guided them in planning ways to create even brief times for practice.

During the second session on communication, the therapist provided psychoeducation about links between one's cognitions and emotional and behavioral responses, using examples that Carla and Santiago had provided that illustrated effects of their thinking on their interactions. For example, Carla became anxious when she associated Santiago's arguing with her father's verbal aggression, whereas Santiago became angry when he attributed Carla's criticism to disrespect and wanting to win a competition with him. The therapist guided them in monitoring thoughts that fueled their negative emotions and behavior (Santiago's pursuit and Carla's withdrawal). She introduced an app for their phones to record their automatic thoughts, emotional responses, and behavior during conflicts. Homework included practice of communication skills and use of thought records and anger management techniques as needed. The next four sessions involved more practice of communication skills, review of completed thought records, and use of anger management. Although their level of partner aggression was only moderate, their deficits in communication and anger management skills required repeated practice during and between those sessions.

When the partners demonstrated ability to use expressive and listening skills in conjunction with intervening with their negative cognitions and anger, the therapist introduced problem-solving skills. She gave each partner a handout that described the steps, modeled the steps, and she then coached Carla and Santiago in applying the process to finding a solution to an issue that both found stressful but not a source of conflict between them (i.e., the difficulty they had in getting their children to go to sleep at a reasonable time). Their homework was to try implementing their plan during the coming week. At the following session, the couple reported that when the children resisted their plan, frustration and anger began to spill into their couple relationship. However, they remembered to initiate a time-out, retreated to self-soothe, and regrouped to brainstorm what to try next. The therapist inquired about automatic thoughts they remembered having at the time and encouraged them to use the app in the future.

The therapist coached the couple during four additional weekly sessions in using communication and problem-solving skills to address issues that involved higher conflict (e.g., Santiago's tendency to be silent when he was uncomfortable during a visit with Carla's parents). She checked on the couple's monitoring and modification of any negative cognitions, as well as their use of anger management techniques. When the therapist and couple agreed that much progress had been made on the therapy goals, they gradually phased out sessions over the next 2 months, while devising steps the couple could take (e.g., practice of communication skills, anger management) if they experienced any lapses in progress on presenting problems.

CONCLUDING COMMENTS

The high prevalence of psychological and physical partner aggression and its deleterious effects on individual and relationship well-being necessitates that couple therapists screen for it. Research has demonstrated that with cases of psychological aggression and mild to moderate physical aggression (but not battering), structured forms of conjoint therapy can be safe and effective. The CCBTPA model described in this chapter addresses empirically identified risk factors for partner aggression, focusing on interventions to modify its cognitive, affective, and behavioral components. By addressing both individual and dyadic interpersonal processes contributing to aggression, this integrative treatment maximizes therapeutic effects.

SUGGESTIONS FOR FURTHER STUDY

Baucom, D. H. (2009). *Enhanced cognitive-behavioral couple therapy* [DVD]. Washington, DC: American Psychological Association.

Rathus, J. H., & Feindler, E. L. (2004). *Assessment of partner violence: A handbook for researchers and practitioners*. Washington, DC: American Psychological Association.

REFERENCES

Ackerman, J., & Field, L. (2011). The gender asymmetric effect of intimate partner violence on relationship satisfaction. *Violence and Victims*, *26*, 703–724.

Afifi, T. O., MacMillan, H., Cox, B. J., Asmundson, G. J., Stein, M. B., & Sareen, J. (2009). Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. *Journal of Interpersonal Violence, 24,* 1398–1417.

Agrawal, S., Sobell, M., & Sobell, L. (2009). The Timeline Followback: A scientifically and clinically useful tool for assessing substance use. In R. F. Belli, F. P. Stafford, & D. F. Alwin (Eds.), *Calendar and time diary* (pp. 57–68). Thousand Oaks, CA: SAGE.

Ahmadabadi, Z., Najman, J. M., Williams, G. M., Clavarino, A. M., d'Abbs, P., & Tran, N. (2020). Intimate partner violence and subsequent depression and anxiety disorders. *Social Psychiatry and Psychiatric Epidemiology, 55,* 611–620.

Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin, 126,* 651–680.

Arkowitz, H., Miller, W. R., & Rollnick, S. (2017). *Motivational interviewing in the treatment of psychological problems* (2nd ed.). New York: Guilford Press.

Capaldi, D. M, Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse, 3,* 231–280.

Cordova, J. V., Warren, L. Z., & Gee, C. B. (2001). Motivational interviewing as an intervention for at-risk couples. *Journal of Marital and Family Therapy, 27,* 315–326.

Crane, C. A., Hawes, S. W., Devine, S., & Easton, C. J. (2014). Axis I psychopathology and the perpetration of intimate partner violence. *Journal of Clinical Psychology, 70,* 238–247.

Crenshaw, K. L. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43,* 1241–1299.

Derogatis, L. R., & Spencer, P. M. (1982). *The Brief Symptom Inventory (BSI): Administration, scoring and procedures manual—I*. Baltimore: Johns Hopkins University School of Medicine.

Devries, K. M., Mak, J. Y., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, B., . . . Pallitto, C. (2013). The global prevalence of intimate partner violence against women. *Science, 340,* 1527–1528.

Dutton, D. G., & White, K. R. (2012). Attachment insecurity and intimate partner violence. *Aggression and Violent Behavior, 17,* 475–481.

Ehrensaft, M. K. (2009). Family and relationship predictors of psychological and physical aggression. In K. D. O'Leary & E. M. Woodin (Eds.), *Psychological and physical aggression in couples: Causes and interventions* (pp. 99–118). Washington, DC: American Psychological Association.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Evans, M. L., Lindauer, M., & Farrell, M. E. (2020). A pandemic within a pandemic—Intimate partner violence during Covid-19. *New England Journal of Medicine, 383,* 2302–2304.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21,* 572–583.

Gilchrist, G., Munoz, J. T., & Easton, C. J. (2015). Should we reconsider anger management when addressing physical intimate partner violence perpetration by alcohol abusing males?: A systematic review. *Aggression and Violent Behavior, 25,* 124–132.

Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy*. New York: Norton.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused couples therapy: The dynamics of emotion, love, and power*. Washington, DC: American Psychological Association.

Greene, B., Boyd-Franklin, N., & Spivey, P. B. (2013). African American lesbians and gay male couples: Threats to intimacy and considerations in couples therapy. In K. Helm & J. Carlson (Eds.), *Love, intimacy and the African American couple* (pp. 148–169). New York: Routledge.

Heyman, R. E., & Neidig, P. H. (1997). Physical aggression couples treatment. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples intervention* (pp. 589–617). Chichester, UK: Wiley.

Hrapczynski, K. M., Epstein, N. B., Werlinich, C. A., & LaTaillade, J. J. (2011). Changes in negative attributions during couple therapy for abusive behavior: Relations to changes in satisfaction and behavior. *Journal of Marital and Family Therapy, 38,* 117–132.

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence against Women, 12,* 1003–1018.

Jose, A., & O'Leary, K. D. (2009). Prevalence of partner aggression in representative and clinic samples. In K. D. O'Leary & E. M. Woodin (Eds.), *Psychological and physical aggression in couples: Causes and interventions* (pp. 15–35). Washington, DC: American Psychological Association.

Kahn, S. Y., Epstein, N. B., & Kivlighan, D. M. (2015). Couple therapy for partner aggression: Effects on individual and relational well-being. *Journal of Couple and Relationship Therapy. 14,* 95–115.

LaTaillade, J. J. (2006). Considerations for treatment of African American couple relationships. *Journal of Cognitive Psychotherapy: An International Quarterly, 4,* 341–358.

LaTaillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy, 20,* 393–410.

Lavner, J. A., Barton, A.W., Bryant, C. M., & Beach, S. R. H. (2018). Racial discrimination and relationship functioning among African American couples. *Journal of Family Psychology, 32,* 686–691.

Makin-Byrd, K., & Azar, S. T. (2011). Beliefs and attributions of partner violence perpetrators: The physical and psychological violence of adolescent males. *Violence and Victims, 26,* 177–190.

Mallory, A. B., Dharnidharka, P., Deitz, S. L., Barros-Gomes, P., Cafferky, B., Stith, S. M., & Van, K. (2016). A meta-analysis of cross cultural risk markers for intimate partner violence. *Aggression and Violent Behavior, 31,* 116–126.

McCollum, E., Stith, S., Miller, M. S., & Ratcliffe, G. C. (2011). Including a brief substance abuse motivational intervention in a couples treatment program for intimate partner violence. *Journal of Family Psychotherapy*, 22, 216–231.

Meichenbaum, D. (1985). *Stress inoculation training.* New York: Pergamon Press.

Murphy, C. M., & Eckhardt, C. I. (2005). *Treating the abusive partner: An individualized cognitive-behavioral approach.* New York: Guilford Press.

Murphy, C. M., & Hoover, S. A. (1999). Measuring emotional abuse in dating relationships as a multifactorial construct. *Violence and Victims, 14,* 39–53.

O'Farrell, T. J., & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse.* New York: Guilford Press.

O'Leary, K. D. (2008). Couple therapy and physical aggression. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 478–498). New York: Guilford Press.

O'Leary, K. D., Heyman, R. E., & Neidig, P. H. (1999). Treatment of wife abuse: A comparison of gender-specific and conjoint approaches. *Behavior Therapy, 30,* 475–505.

Poleshuck, E., Mazzotta, C., Resch, K., Rogachefsky, A., Bellenger, K., Raimondi, C., . . . Cerulli, C. (2018). Development of an innovative treatment paradigm for intimate partner violence victims with depression and pain using community-based participatory research. *Journal of Interpersonal Violence, 33,* 2704–2724.

Rathus, J. H., & Feindler, E. L. (2004). *Assessment of partner violence: A handbook for researchers and practitioners.* Washington, DC: American Psychological Association.

Robertson, K., & Murachver, T. (2009). Attitudes and attributions associated with female and male partner violence. *Journal of Applied Social Psychology, 39,* 1481–1512.

Robertson, K., & Murachver, T. (2011). Women and men's use of coercive control in intimate partner violence. *Violence and Victims, 26,* 208–217.

Rolle, L., Giardina, G., Caldarera, A. M., Gerino, E., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology, 9,* Article 1506.

Slootmaeckers, J., & Migerode, L. (2019). Fighting for connection: Patterns of intimate partner violence. *Journal of Couple and Relationship Therapy, 17,* 294–312.

Spivak, H. R., Jenkins, E. L., VanAudenhove, K., Lee, D., Kelly, M., & Iskander, J. (2014). CDC grand rounds: A public health approach to prevention of intimate partner violence. *Morbidity and Mortality Weekly Report, 63,* 38–41.

Stephenson, R., & Finneran, C. (2017). Minority stress and intimate partner violence among gay and bisexual men in Atlanta. *American Journal of Men's Health, 11,* 952–961.

Stets, J. E. (1988). *Domestic violence and control.* New York: Springer-Verlag.

Stith, S. M., McCollum, E. E., & Rosen, K. H. (2011). *Couples therapy for domestic violence: Finding safe solutions.* Washington, DC: American Psychological Association.

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30,* 305–318.

Stith, S. M., Spencer, C. M., Ripoll-Nunez, K. J., Jaramillo-Sierra, A. L., Khodadadi-Andariyeh, F., Nikparvar, F., . . . Metelinen, J. (2020). International adaptation of a treatment program for situational couple violence. *Journal of Marital and Family Therapy, 46,* 272–288.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283–316.

Ulloa, E. C., & Hammett, J. F. (2016). The effect of gender and perpetrator–victim role on mental health outcomes and risk behaviors associated with intimate partner violence. *Journal of Interpersonal Violence, 31,* 1184–1207.

Wrape, E. R., & McGinn, M. M. (2018). Clinical and ethical considerations for delivering couple and family therapy via telehealth. *Journal of Marital and Family Therapy, 45,* 296–308.

Yllo, K. (1993). Through a feminist lens: Gender, power, and violence. In R. Gelles & D. Loseke (Eds.), *Current controversies on family violence* (pp. 47–63). Newbury Park, CA: SAGE.

CHAPTER 18

Couple Therapy for Infidelity

**Kristina Coop Gordon, Erica A. Mitchell,
Donald H. Baucom, and Douglas K. Snyder**

BACKGROUND

Couples in which a partner has had an extradyadic affair are not a rarity. Studies with large, representative U.S. samples across all age cohorts have found that approximately 21% of men and 13% of women have at some time participated in sex outside of their primary relationship (e.g., Labreque & Whisman, 2017). When asked about infidelity in the past year alone, about 4% of men and 2% of women report engaging in extramarital affairs (Labreque & Whisman, 2017). Furthermore, whereas the Internet has created more avenues for people to connect with others outside of their relationships, exact rates of Internet infidelity are unknown (Vossler, 2016). Thus, although there is speculation that online interactions have increased couples' ability to engage in infidelity, it is unclear whether this hypothesis is borne out by data, as the total rates of infidelity (representing all types, including cyberinfidelity) reported by Labreque and Whisman (2017) have remained consistent across multiple decades. Regardless of how it occurs, infidelity often has devastating consequences for both partners, such as the onset of depression, anxiety, posttraumatic stress disorder (PTSD), and intimate partner violence (Cano & O'Leary, 2000; Kaighobadi, Shackelford & Archer, 2009; Roos, O'Connor, Canevello, & Bennett, 2018), as well as lower marital quality (Previti & Amato, 2004) and higher likelihood of divorce (Allen & Atkins, 2012).

Given the prevalence of infidelity and its potential for damage to a relationship, it is not surprising that approximately 30% of couples begin therapy because of the effects of an affair (e.g., Whisman, Dixon, & Johnson, 1997). Despite this high rate, practicing couple therapists often feel underprepared to work effectively with infidelity disclosures in therapy and reliably rank extramarital affairs as one of the most difficult problems to treat (Softas-Nall, Beadle, Newell, & Helm, 2008; Whisman et al., 1997). The treatment outlined in this chapter provides a comprehensive model to address the difficulties that therapists and couples experience as they attempt to move forward in their relationships by integrating literature from the fields of interpersonal forgiveness and the response to traumatic events (Gordon & Baucom, 1998; Gordon et al., 2019). For further explication of this treatment, readers are referred to a more detailed clinical manual by Baucom, Snyder, and Gordon (2009) and to a self-help guide for couples (Snyder, Baucom, & Gordon, 2007).

It is our belief, along with others in the field, that conceptualizing affairs as a form of interpersonal trauma helps therapists understand the cognitive, behavioral, and emotional disequilibrium that often follows an affair and formulate more helpful treatments (e.g., Gordon, Baucom, & Snyder, 2008). The traumatic response literature suggests that people are most likely to be emotionally traumatized following an event that violates their assumptions regarding how the world and others operate (e.g., Resick, Monson, & Chard, 2016); that is, individuals often hold cherished assumptions about their partners and their relationships, such as "We've promised each other that we would always be faithful" or "I can depend on my partner to be honest with me" (Gordon et al., 2008). Similarly, involved partners (the ones who had the affair) can be traumatized by their own actions, which often violate values of fidelity and trustworthiness, and by their injured partners' actions, which often create uncertainty about the future of the relationship (Scuka, 2015). When deeply held assumptions are violated, both partners may experience a loss of control and safety regarding themselves, their partners, and their relationship, often resulting in anxiety and depression (e.g., Cano & O'Leary, 2000; Scuka, 2015). Therapies based on trauma theory attempt to restructure clients' schemas about how the world operates and help them regain a sense of control over their lives (e.g., Resick et al., 2016).

Forgiveness-based interventions are similar to trauma-based therapies in their approaches to helping people get past the shock and emotional pain of interpersonal betrayals. These interventions focus on helping individuals develop a greater understanding of why the betrayal took place. These treatments help both partners potentially increase their levels of empathy and positive feelings toward each other and decrease anger and hostility in the injured partner (e.g., Worthington & Wade, 2019). Although different theories regarding forgiveness have unique elements, most are similar with regard to how they define the forgiveness of an interpersonal betrayal. These definitions usually contain three common components: (1) gaining a more balanced view of the offender and the event; (2) decreasing negative affect toward the offender, potentially with increased compassion; and (3) giving up the right to punish the offender further or to demand restitution (Gordon et al., 2019).

Both trauma and forgiveness treatments have demonstrated efficacy in guiding individuals through recovering from traumatic experiences; however, neither has focused specifically on dealing with the intricacies of treating couples who have experienced an affair. To meet couples' specific needs in the treatment of interpersonal trauma from a dyadic perspective, our treatment also draws from two empirically supported couple therapy approaches: cognitive-behavioral couple therapy (CBCT) and insight-oriented couple therapy (IOCT). CBCT (see also Chapter 3, in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade) builds on skills-based interventions of behavioral couple therapy by targeting couple communication and behavior exchange, and directing both partners' attention to the explanations they construct for each other's behavior, as well as to expectations and standards they hold relative to their own relationship and relationships in general (Baucom, Fischer, Corrie, Worrell, & Boeding, 2020; Epstein & Baucom, 2002). Because an affair discovery typically leads to emotional turmoil and destructive exchanges, the structured, directive strategies in cognitive-behavioral interventions provide focus and direction at a time when these elements are often lacking. Moreover, in exploring factors that placed their relationship at risk, partners frequently need to negotiate changes in how they interact and manage daily challenges. CBCT is particularly well suited to these therapeutic objectives; however, CBCT's usual focus on the present and the future leaves important gaps, as many couples report that they cannot move forward and put the affair behind them; they need a way to process the trauma that occurred and make sense of the past.

Therefore, it also is useful to draw from IOCT (see Snyder & Mitchell, 2008), an approach that is designed specifically to help partners have a greater understanding of how the past affects current relationship struggles (Snyder, 1999). This improved understanding of both partners' developmental histories, and the role that developmental experiences play in current and past relationships, can aid in transforming an injured partner's understanding of how the involved partner could make the decision to engage in an affair (for a complementary perspective, see Chapter 9, "Intergenerational Factors in Couple Therapy," in this volume, by Fishbane). Furthermore, these revelations of vulnerability may have the added benefit of allowing partners to develop more mutual empathy and compassion. Increased insight and empathy also help partners develop a more coherent narrative regarding the affair, as well as a better perspective on future changes that need to take place if their relationship is to feel more secure. Thus, the couple interventions for addressing infidelity outlined in this chapter draw on cognitive-behavioral interventions integrated with insight-oriented approaches to provide a treatment strategy that balances the past, present, and future.

CORE UNDERSTANDINGS ABOUT COUPLES DEALING WITH INFIDELITY

There are multiple ways that individuals and couples can respond to the disclosure or the discovery of an affair. Although extradyadic affairs often lead to negative relational outcomes, not all couples separate or divorce, nor are the long-term effects of affairs always negative. Some research has indicated that it can even serve as an impetus for tackling issues that have caused difficulties throughout the relationship (e.g., Atkins, Eldridge, Baucom, & Christensen, 2005), resulting in overall improvements in relationship quality long term (Vossler & Moller, 2014). However, surveys of clinicians who work with couples reveal that very few treatment providers view infidelity as relationship-enhancing (e.g., Glass, 2002). We have found in our clinical experiences and our review of the literature on infidelity that a number of factors regarding a couple's relationship can affect the couple's ability to recover from the affair.

First, not all relationships are the same, and some distinguishing characteristics of the couple and the couple's relationship are predictive of successful recovery. For example, involved partners (i.e., the partner who had an affair) who are more satisfied with their relationship and are less approving of infidelity are more likely to feel remorseful (e.g., Allen & Baucom, 2005; Kaplanova & Gregor, 2019), which generally improves the effectiveness of couple therapy. A couple's ability to discuss openly and productively the affair and its antecedents is also a good prognostic indicator for recovery (e.g., Gordon, Baucom, & Snyder, 2000, 2004; Vossler & Moller, 2014). Furthermore, some research suggests that the involved partner answering the injured partner's (i.e., the partner who did not have an affair) questions about the affair helps bolster the injured partner's sense of predictability and control regarding the relationship (Softas-Nall et al., 2008); however, therapists should help partners carefully decide what to ask, as knowing everything is often not conducive to healing (Baucom et al., 2009; Weeks & Treat, 2001).

In addition, both partners' assumptions around sexual, cognitive, and emotional monogamy in the relationship can play a role in the response to an affair. For example, many people assume that they will be the only persons to whom their partners are attracted, and that their partners will refrain from emotional and romantic involvements with anyone else. The disruption of any of these assumptions can lead an individual to feel emotionally devastated; thus, the individual may enter therapy with a strong sense of betrayal. For this reason, having a comprehensive view of infidelity, something akin to Glass's definition of infidelity: "a secret sexual, romantic, or emotional involvement that violates the commitment to an exclusive relationship" (2002, p. 489), is important. The notion that *extradyadic sexual contact is not necessary for one to feel betrayed* is supported by studies of individuals who have experienced "cyberinfidelity" (i.e., extradyadic relationships via electronic means such as chat rooms, social networking sites, e-mail) in their relationships. Research has revealed that cyberinfidelity is becoming increasingly common and is as serious as other types of infidelity in terms of its effect on couple functioning. One study found that nearly one-fourth of injured partners had divorced, and roughly two-thirds had lost interest in sex (Schneider, 2002). Despite its increase in frequency, cyberinfidelity remains difficult to define (Vossler, 2016), which may be due to the common overlap with in-person encounters. For example, one study revealed that approximately 65% of individuals who seek sexual encounters online report engaging in physical sex with their Internet partners offline (Rietmeijer, Bull, & McFarlane, 2001).

Furthermore, research has demonstrated that attitudes and agreements between partners regarding extradyadic involvement can vary widely, and these differences in expectations can have important implications for recovery from an affair (e.g., Martell & Prince, 2005). For instance, an involved partner who adheres to religious beliefs that strongly disapprove of sexual relationships outside marriage may have problems reconciling their religious identity with engaging in this behavior, along with the difficulties inherent to the recovery process. Likewise, because some cultures pose differing expectations based on gender (e.g., Roberts & Flaskerud, 2008), infidelity may be more tolerated by the injured partner if there are subtle expectations that infidelity is common for the involved partner's gender. In addition, in same-sex relationships, some gay men view nonmonogamy as a rejection of cultural norms rather than a betrayal of the primary relationship (Greenan & Tunnell, 2003; also see Chapter 23 on queer couples, in this volume, by Coolhart). Thus, it is important that the therapist properly assess underlying cultural and religious values or beliefs that may influence the processes leading up to and recovery from a relationship betrayal.

Finally, more general contextual factors, such as the nature of the affair and the behavior of the outside affair partner, also are likely to influence recovery. For example, when the involved partner remains in contact with the outside affair partner, the injured partner may experience a more severe and long-lasting traumatic reaction because it impedes the possibility of regaining a sense of safety and may increase the chance of divorce or separation (e.g., Glass 2003). Similarly, we have found that even if the involved partner ends the affair, if the affair partner continues to initiate contact with either partner, the injured partner can be continually retraumatized. Thus, the therapist should intervene quickly in such a case and help the couple recognize the likely detrimental effects of such continued contact, including ways to end such interactions. Furthermore, the nature of the affair can influence individual responses; an involved partner who feels satisfied or fulfilled by the affair relationship is less likely to feel remorse or guilt for having engaged in the affair (Allen & Baucom, 2005). Likewise, an affair that involves both sexual and emotional infidelity seems to be the most relationally disruptive. Indeed, a study revealed that husbands rarely left their marriages if they had participated in affairs that were primarily sexual (Glass, 2003). Finally, particular contextual factors within the relationship (e.g., one partner involved in military deployment) may present unique challenges (e.g., Snyder, Balderrama-Durbin, & Fissette, 2012; Snyder, Gasbarrini, Doss, & Scheider, 2011). This necessitates that the therapist evaluate these factors at the start of treatment and consider adjusting the treatment plan to best fit these circumstances.

THE PRACTICE OF COUPLE THERAPY FOR RECOVERY FROM AN AFFAIR

As noted earlier, this treatment draws from cognitive-behavioral and insight-oriented approaches, as well as the forgiveness and traumatic response literatures to provide a flexible approach to treatment. This approach allows the therapist and couple to explore the couple's past experiences to increase their current understanding of their relationship and make good decisions about their future.

The Structure of the Therapy Process

This treatment is typically conducted with both members of a couple present. However, often the involved partner is reluctant to come for treatment out of a concern it might lead to greater damage to the relationship or concern that they might be viewed in harsh, negative ways. Likewise, this partner may be ambivalent about the relationship and reluctant to invest more time in improving it. It can be helpful for the therapist to encourage a reluctant partner to come for an exploratory visit, without yet making a commitment to an ongoing therapy process. In this visit, the therapist can address the partner's concerns. Ideally, if the therapist can demonstrate a supportive atmosphere, as well as a compelling rationale for the process of therapy, then a reluctant partner may be willing to enter treatment. However, if either partner refuses to attend therapy or cannot participate due to logistical complications, the principles outlined in this chapter can potentially be helpful in guiding the other partner toward healthy decisions or recovery from the affair.

Although this treatment is best conducted in a conjoint format, individual sessions, if handled carefully, can be helpful; however, it is critical to clarify the principles regarding confidentiality for the individual sessions to both partners during the conjoint sessions (for approaches to confidentiality, see Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen). This requirement is necessary to create an atmosphere of safety that not only allows the partners to air their genuine feelings about the situation and their goals regarding the couple therapy in the individual sessions, but also protects the therapist against the uncomfortable experience of holding secrets. Therapists can handle confidentiality in individual sessions in a number of ways. We typically consider individual sessions to be confidential, with exceptions as explained below. More specifically, we explain that our primary "client" is the relationship. Therefore, we make it clear to clients before they disclose information contrary to what has been said in conjoint sessions that we will not hold a secret we consider to be detrimental to the couple therapy; thus, these individual sessions are not wholly confidential. For example, the injured partner might be accessing the involved partner's e-mail account without their knowledge. If such information is disclosed in an individual session, the therapist is encouraged to support the injured partner in sharing this with the involved partner in session. Furthermore, the therapist should help the couple figure out ways that they can both be more transparent in the immediate aftermath of the discovery to help rebuild trust. However, we also emphasize that if a client needs to reveal information that might compromise physical safety (e.g., to report severe partner abuse), then we will not disclose information that might harm this client. With regard to continuing treatment, we approach issues of relational violence as is generally practiced in couple therapy (see below; also see Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich).

One of the reasons we schedule individual sessions early in the assessment process is to work with each partner on individual functioning and emotion regulation strategies. We assess whether an individual might benefit from adjunct individual treatment or a referral for pharmacological treatment. If we do make these referrals, we find it critical to maintain contact with individual therapists to coordinate treatment; the extent to which both therapists can be open about their treatment goals and coordinate efforts can greatly affect the success of both treatments. Finally, we occasionally also schedule individual sessions during treatment to restore the therapeutic alliance and to provide extended individual exploration and support if it becomes clear that the presence of the partner is substantially impeding an individual's ability to explore their own contributions to the relationship problems. This decision is typically made only when the therapy is clearly "stuck."

Consistent with most couple therapists' experience that affairs are particularly difficult to treat, the length of treatment can vary from months to years, depending on the complexity of the case. For example, if the extradyadic partner is someone with whom the couple will continue to have contact (e.g., a neighbor, when the couple is unable to move), this will need to be addressed in therapy and is something the couple will continue to have to navigate over time. However, these longer treatments usually are not solely focused on recovery from the affair. In such instances, partners are typically able to recover from the affair earlier in treatment but may still have a number of more general issues in their relationship and lives that require additional attention and work. As in most other treatments, the length of the therapy has much to do with the overall psychological health of the partners. With couples for whom there is significant psychopathology, such as personality disorders, or the injury is complex and deep-rooted, therapy tends to take longer and be more complex. These couples also may require more balancing of conjoint and individual sessions.

Furthermore, because addressing infidelity often engages volatile emotions and crises between the partners can arise on a regular basis, we believe that the therapist should initially meet with the couple at least once a week. If the couple is particularly volatile, and the risk of severe conflict escalation is particularly high, then it is advisable to consider meeting more frequently until the situation stabilizes. As the need for damage control decreases, the therapist and couple can decide together whether and when to reduce session frequency. Finally, given that these couples often enter into treatment in severe crisis, contacts between sessions may also be needed to minimize damage or destructive interactions at home. However, despite our model's openness to between-session contact for specific purposes, we ask couples to follow certain guidelines, so that such contacts are handled appropriately. These contacts are not times when one partner can complain or attack the other partner. We also ask that a partner inform the other person if such a contact has been made. In this way, we avoid the perception of unintended alliances or secrets with one partner.

The Role of the Therapist

A strong alliance between the therapist and couple is crucial in treating infidelity successfully, and several initial tasks are critical in creating the optimal therapeutic relationship with these couples. The most important task for the alliance is establishing an atmosphere of safety and trust. Both partners need to know that their thoughts and feelings will be heard and respected, and that they will not be attacked or belittled during sessions. To achieve this safe atmosphere, the therapist must intervene quickly and directly in the couple's discussions to limit the amount and types of negativity expressed during the session. Offering a rationale for interrupting and redirecting partners' destructive exchanges promotes tolerance for such interventions. In addition, both partners need to know that they will not be pushed to disclose material that they are not ready to address, and that the therapist will respect the couple's preferred pace of therapy, while attempting to minimize unproductive avoidance.

The second major task is to promote partners' belief and trust in the therapist's competence. Couples struggling with the aftermath of infidelity need to feel confident that the therapist has the expertise to treat these kinds of relationship trauma. The first way we demonstrate our expertise in treating affairs is by providing a normative context for the couple's struggles. Partners dealing with the aftermath of an affair need a framework for understanding what is happening to them. Describing common responses to affairs for both the injured and the involved partner (1) allows them to make better sense of their own and each other's current behaviors, (2) gives them hope for recovery, and (3) creates more realistic expectations for the course of treatment. Finally, trust in the therapist's expertise allows partners to participate more willingly when they confront difficult situations in the context of treatment.

The third task is affirming fairness to both partners. Even when two partners present simultaneously for couple therapy and agree to identify their relationship as the "client," conflicts of interest may be unavoidable—for example, when partners differ in mental or physical health, or when caring for one partner requires decisions that have negative consequences for the other. For example, when one partner is suicidal, the therapist may have to proceed more slowly and cautiously than normal; this change in pace can present a challenge when the suicidal client is the involved partner and, consequently, the injured partner may feel that their needs are being overlooked or not being addressed quickly enough. Challenges in ensuring fairness to both partners can sometimes be addressed, at least in part, by clearly articulating the nature of this challenge to both partners.

Finally, there are several ethical issues particular to the treatment of couples following affairs (Snyder & Doss, 2005), but two are most critical. First, the heightened level of negative emotion means that assessing for physical violence between the partners is imperative. Therapists should gather information about both the frequency and severity of aggression and inquire about this in a tone that conveys concern for both the partners and their relationship. If aggression is present, then the therapist must quickly intervene to terminate aggressive behaviors, both within and between sessions. Previous research indicates that the risk for intimate partner violence is heightened when one partner suspects or discovers that the other partner has been involved in an extradyadic relationship (e.g., Kaighobadi et al., 2009). The therapist should establish a safety plan with any partner who feels that they are in danger. If the level of physical force is minor and does not appear to present significant danger to either partner or risk escalation, then the therapist might address this issue through directed problem solving and careful use of time-out procedures (also see Chapter 17 on partner aggression, in this volume, by Epstein et al.). The therapist must set clear expectations that any physical aggression will not be tolerated. Second, unique risks posed by sexual exchanges with an outside person also present ethical challenges to the therapist and the couple. Consequently, it is important to evaluate (1) whether the affair involved sexual contact and, if so, whether there was intercourse in which there was no protection against sexually transmitted infections (STIs) and (2) whether both partners have been tested for HIV or other STIs since the affair. If both partners have not been tested, the therapist should encourage them to consider this and provide space in therapy to process what this means for each of them, and furthermore to process the test results.

Assessment and Treatment Planning

The first stage of treatment encompasses assessment and management of the affair's impact. An array of relationship health measures can assess basic aspects of couple functioning such as satisfaction, communication skills, and commitment level (also see Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin). Typically, we give these measures to a couple at the first session and ask that they complete them separately and return them at the next session. These measures can help guide the therapist in gathering information about the couple's relationship history. In addition, the therapist should ask about previous affairs, separations, or experiences in couple counseling, as well as the circumstances surrounding each of these. Furthermore, individual assessment sessions, one for each partner, are beneficial to assess sensitive information about individual or relationship functioning that partners may be reluctant to share in early conjoint sessions, with the understanding that such information will be explored further in later conjoint sessions.

Next, it is important to identify issues or crises requiring immediate attention, such as the extent of disruption in the partners' major patterns of interacting. For example, are the partners still sharing meals or sleeping together? If they have children, have both partners been able to maintain essential parenting roles, either separately or collaboratively? What assistance does the couple require immediately for containing the crisis? In addition, it is important to assess the content and regulation of partners' emotions. To what extent does either partner struggle to manage overwhelming feelings of hurt, anger, fear, loss, guilt, or shame? For example, the involved partner might be so sensitive to feelings of shame about the affair that they avoid the injured partner's efforts to discuss it, which in turn leads the injured partner to escalate these attempts. As described earlier, when the therapist is inquiring about the couple's abilities to regulate strong feelings, it is critical to assess the level of partners' verbal and physical aggression.

Another major issue that many couples face upon the disclosure or discovery of an affair involves who should know about it. Should the partners tell their children, extended family members, friends, or coworkers? If couples do not handle this issue well, it can cause significant future problems. For example, partners' relationships with their children or with their own or each other's extended family can be irrevocably damaged when family members learn that a partner has had an affair. If the affair happened in a work setting, then punitive actions by the injured partner, such as informing the involved partner's employer, can produce adverse impacts and enduring financial hardships for multiple people. It is important to assess how the partners are addressing such decisions early in treatment and to provide explicit guidelines, as needed, to help them navigate these issues.

Additionally, the therapist may desire to collect information regarding the ethnic, cultural, and religious background of both partners and explore how these factors may influence involvement in or ability to recover from the affair. Partners may benefit from gaining an understanding of how their cultural or religious upbringing contributed to the affair and what aspects of their personal moral or religious beliefs may aid or impede their ability to reconcile what has happened in their relationship. Likewise, because research indicates that differences in expectations regarding monogamy may exist between partners (e.g., Greenan & Tunnell, 2003), the therapist should assess differences in the partners' conceptualization of infidelity.

Furthermore, it is important during the initial assessment to address several questions regarding the outside relationship. The therapist should determine the nature and status of the affair. If it was sexual, when and how did it become sexual? If the affair has ended, is this ending just temporary or is it permanent? What contact has either partner had with the outside person since the end of the affair? What steps, if any, have been taken to ensure that no further contact takes place, or are there agreements between the partners regarding what types of contact are acceptable at this point? Evaluating the involved partner's previous and current contact with the outside affair partner is critical to understanding ongoing sources of continued turmoil and the likelihood of restoring emotional security in the couple's relationship. Obtaining relevant information can be complicated in some cases because the involved partner may not disclose the full degree of contact with the outside person to the injured partner and the information could be volatile. Thus, exploring this information in individual sessions could be more productive, while balancing the principle of not keeping secrets by supporting the involved partner in sharing this information with the injured partner in session, where the therapist can provide safety and assist with emotional processing. Furthermore, it is important to gain information about the person with whom the involved partner had the affair. What are this other person's goals or expectations? Is this person married or in a committed relationship? If so, does this person's partner know? Was the affair a one-night stand or ongoing? Was the extramarital behavior with someone known or a sex worker? This information helps the therapist to assess the complexity of the situation and the depth of the injury, which can provide some predictability regarding the difficulty and length of treatment.

The therapist should also inquire about the potential consequences of the affair. Who else knows about the affair? Are there any complications at work or other legal problems? Could the outside person, or their partner, make the couple's lives more difficult if either individual decided to do so? Thus, understanding the other person's life situation can help to clarify how complicated it might be to handle the affair emanating from forces outside of the couple.

If it is revealed that the affair has not ended, but its existence is known by the injured partner and both partners wish to continue in therapy, continuing with treatment is up to the therapist's clinical judgment. Our position is that to end therapy at that point might be premature. Instead, we advocate that initial interventions focus on negotiating with the partners whatever intermediate boundaries on contact with the outside person they can agree and adhere to. Moreover, the partners are likely to be in a better position to make long-term decisions about how they want to proceed with their relationship after they complete treatment.

Finally, the therapist should assess the specific stressors that impact the couple, as well as the partners' individual and joint resources that can be brought to bear on the situation. Common responses to an affair that can increase or perpetuate stress include anxiety or depression, misuse of alcohol or other substances, suicidal thoughts or behaviors, or physical aggression. Additional stressors may include excessive demands from work or family responsibilities that further drain one or both partners, or concerns related to finances, physical health, or children's well-being. The therapist should also assess for resources to help cope with these stressors. For example, the therapist might ask the partners to explain how they and their children are continuing to manage despite the challenges. What has been the most helpful to them—in terms of their own resources, responses from each other, or external social support? Common resources that can buffer the adverse impact of an affair or render recovery more promising include a history of strong emotional connection and positive interactions prior to the affair, shared values or commitment to common goals (including caring for the children), support for the couple's relationship from family and friends, and healthy patterns of separate interests or pursuits that facilitate tolerance of current disruption in the couple relationship.

Goal Setting

Often the most salient goal when a couple begins treatment is clarifying whether the partners plan to continue or end their relationship or are uncertain regarding its future. Some degree of ambivalence about the future of the relationship is common for either injured or involved partners. We typically address this issue by reassuring both partners that the goal of therapy is not to maintain the relationship unless it is a healthy relationship for both of them, and we normalize their ambivalence about the marriage. However, we also assert that by going through the process of therapy, the information they gain about themselves will allow them to make the best decision about staying together or not.

In addition, each stage of treatment has its own particular set of goals. Given that dealing with an affair first involves addressing the impact of the event, the treatment components for Stage 1 of the therapy are primarily cognitive-behavioral and directly target problems that arise from the immediate impact of the affair (e.g., emotional dysregulation, depression, the need to express feelings of anger and hurt, and "damage control" when necessary). This stage also focuses on problem solving and dealing with immediate issues. The goal of Stage 2 is to understand the meaning or the context of what happened from both a more recent and a historical perspective; therefore, treatment strategies in Stage 2 of the therapy combine cognitive-behavioral and insight-oriented approaches. Consequently, to the extent possible, and whenever appropriate, partners' empathy for each other's experiences at the time of the affair is promoted to aid in the reduction of anger and to increase understanding of each person's decisions (and, if appropriate, to increase feelings of intimacy and closeness between the partners). Finally, in Stage 3, the partners are encouraged to (1) address the issue of forgiveness, (2) consolidate what they have learned about each other, (3) reexamine their relationship, and (4) decide whether or how they wish to continue their relationship in the future. The components and challenges of each stage are described in further detail below. Finally, as in all stage models, these stages are not necessarily linear; the therapist and the couple may cycle through elements of the stages at different times throughout treatment.

Process and Technical Aspects of the Treatment

Stage 1: Dealing with the Impact of the Affair

To begin therapy, therapists should provide the partners with a summary of the current problems the partners appear to be facing in their relationship and a proposed treatment plan. Then the couple should be given an explanation of the stages of the recovery process and the response to trauma conceptualization described earlier in this chapter. This discussion serves several purposes. It orients the partners to treatment and gives them a "map" of where they are likely to go. It also can help them feel understood and supported by the therapist, and it can serve the crucial function of helping them begin to see the "big picture" of their relationship and how the affair might fit into it. A discussion of the notion of "trauma" can help partners to reframe the reactions that they are having and can help them begin to develop empathy for each other's struggles. Finally, this explanatory framework can normalize their experiences and provide a rationale for the treatment plan and course of therapy.

Stage 1 of treatment incorporates five sets of interventions: (1) problem solving and damage control, (2) time-outs and "venting" techniques, (3) self-care techniques, (4) emotional expressiveness skills and discussion of the impact of the affair, and (5) coping with flashbacks.

The negative emotions following the betrayal may have a damaging impact on many other aspects of the couple's functioning. Given that partners are likely to experience a high level of conflict that often occurs at a much higher frequency than usual, they are likely to need immediate assistance from the therapist in setting limits or boundaries on their negative interactions. The therapist should help the partners using directed problem solving to find effective but often temporary solutions for damage control. The involved partner may have to agree to some behaviors that would be atypical in most relationships over the long term but may be needed in the short term to help the injured partner regain a sense of control or safety and to demonstrate remorse for the affair. For example, if a common cause of arguments is one partner's insecurity over the involved partner's whereabouts after learning of the affair, then the involved partner may agree to be zealous in checking in with the other partner until some trust or security has been reestablished. Furthermore, due to the heightened level of negative affect in the period following the discovery of an affair, many partners need a strategy that allows them to disengage when the level of emotion becomes too high. Time-out strategies are introduced, and the partners are instructed on how to recognize when they need to call a time-out and how to do so effectively.

Whereas many couples may be emotionally volatile following the discovery of an affair, others may present as disengaged and minimize their reactions to the affair. This lack of affect from one or both partners regarding the affair may be addressed in two ways, depending on its source. First, if lack of affect is due to a fear of exploring the emotions, then the therapist should address those fears and misunderstandings with a more thorough rationale for and collaborative discussion of this stage of treatment. However, if it is due to an individual's more general difficulty in engaging with others emotionally, more time should be spent helping this person to feel safe to acknowledge and explore their feelings.

Partners also can become involved in a vicious cycle, wherein feelings of anger, anxiety, depression, shame, and lowered self-esteem make them less effective in their interactions with each other, which in turn makes them more depressed or anxious. Thus, another major target for this stage of therapy involves helping both partners take better care of themselves, so that they will have more emotional resources as they work through the aftermath of the affair. Our approach offers basic self-care guidelines that encompass three areas: (1) physical care; (2) social support, paying careful attention to what is and is not appropriate to disclose; and (3) spiritual support (e.g., meditation, prayer, and talking with a spiritual counselor), if this is consistent with the partner's belief system.

A common need for the injured partner in this early stage is to express to the involved partner how hurt or angry they feel by the affair in an attempt to communicate that what happened was wrong and to ensure that the involved partner does not engage in such behaviors again. However, these interactions between the partners are often rancorous and complicated by feelings of anger and shame on the part of the involved partner. Often, the involved partner has feelings of bitterness about an earlier issue or betrayal in the relationship, and these feelings interfere with the ability to sympathize with the injured partner's feelings of betrayal. Consequently, this may leave the injured partner feeling more vulnerable and angry than before the interaction occurred, which may in turn perpetuate a negative cycle of interactions between the partners. This treatment seeks to interrupt this cycle through three means. First, couples are taught emotional expressiveness skills for both speaker and listener, and they are given a careful conceptualization of why this step is necessary. The involved partner must understand that their own perspective on the affair is not likely to be heard and fully understood by the injured partner unless the injured partner first perceives that the involved partner (1) truly understands the meaning of one's actions, (2) is remorseful for the effect of these actions on the injured person and their relationship, and (3) communicates this understanding and remorse clearly to the injured partner. The involved partner is reassured that their own issues will be addressed in Stage 2 of therapy, at which time they are more likely to be heard.

The injured partner might also be encouraged to write a letter expressing their feelings and reactions to the affair, which may first be given to the therapist. After feedback from the therapist, the letter is sometimes revised. This process allows the injured partner to find a way to express their reactions in ways that are not attacking or abusive. Consequently, when the letter is finally read aloud in a subsequent conjoint session, the involved partner often hears a vulnerability that they might not have experienced otherwise. The therapist helps the involved partner to respond empathically to these feelings, thus providing the couple with a more positive exchange regarding these painful experiences than the partners are likely to accomplish on their own.

A final component in Stage 1 is the explanation of "flashback" phenomena and the development of a plan to cope with them. Because the reaction to an affair strongly parallels a traumatic response, both partners may encounter "reexperiencing" phenomena when dealing with an affair. For example, an injured partner who discovers an unexplained number on a telephone bill may then be reminded about the unexplained telephone calls during the affair, triggering a flood of affect related to the partner's affair. If the involved partner is not aware of this sequence of events, the injured partner's emotions may seem exaggerated or just, which may in turn cause the involved partner to question their progress in recovering from the affair. When these processes are explained and normalized, the partners may be less likely to misattribute such interactions to lack of progress. Instead, they have a better conceptualization of what is happening, and they are given the opportunity to problem-solve what each person needs to do in coping with these situations effectively.

Stage 2: Finding Meaning

Stage 1 interventions provide a foundation for Stage 2, which focuses on helping the couple to explore and understand the context of the affair. First, the couple must understand the rationale for this exploration and, optimally, be motivated to engage in this process. The focus of the therapy then turns toward examining the different factors that may have influenced the partner's decision to have the affair. These factors may include (1) aspects of the relationship, such as difficulty communicating or finding time for each other; (2) external issues, such as job stress, financial difficulties, or in-laws; (3) issues specific to the involved partner, such as beliefs about romantic relationships or individual insecurities; and (4) issues specific to the injured partner, such as their own developmental history or relationship skills.

These sessions typically are conducted in two ways. Depending on the partners' level of skills and their motivation to listen to and understand each other, these sessions may take the form of guided discussions between partners as they attempt to understand the many factors contributing to the affair. The therapist intervenes as necessary to highlight certain points, to evoke and strengthen positive emotional experiences between the partners, to reinterpret distorted cognitions, or to draw parallels or inferences from partners' developmental histories that they are not able to discern themselves. However, if their communication skills are weak, if either partner is acutely defensive, or if they have difficulty understanding each other's positions, then the therapist might become more directly involved in three-way conversations with the couple in order to focus and direct the conversation. Thus, at any given moment, the therapist might focus primarily on one partner, while the other partner listens and occasionally is asked to summarize understanding of what is being expressed, or to contribute their own perspective on the issues being discussed. Both partners' perspectives are addressed, with the therapist weaving them together as appropriate and, when possible, turning the conversation back to the two partners to continue between them.

The therapist consistently works to promote empathy between the partners by helping the listening partner draw parallels between what the other is describing and their own similar experiences, or by encouraging the partners to use their imaginations and put themselves in each other's place as best they can. In addition, the therapist looks for patterns and similarities between what the partners have reported in their individual histories and the problems they report in their relationships. It is in these aspects of the therapy—promotion of empathy and developmental exploration—that the treatment borrows most heavily from insight-oriented approaches. Understanding how early experiences or relationship injuries could influence an individual's choices in the present can be a critical element in understanding why an involved partner chose to have an affair, or how an injured partner has responded to this event. Often the choice to have an affair in response to present problems is influenced by strategies that have worked in previous relationships, or by developmental needs that were not met in the past. For example, someone who was repeatedly rejected sexually in early adolescence and young adulthood, and consequently sees oneself as unlovable and undesirable, may be particularly vulnerable to engaging in a sexual affair to address feelings of rejection and abandonment in the current relationship. Helping both partners to recognize and understand such influences may serve to increase empathy by changing partners' understanding of why the affair occurred. This understanding also can help promote healthier responses to such developmental influences.

Throughout the sessions, the need to make changes in aspects of the relationship and themselves as individuals may become evident to partners, and they may naturally begin to engage in problem solving. If not, it is beneficial to build in separate problem-solving sessions on these issues. As a result, the therapist needs to balance the work of therapy between focusing on the affair and focusing on ongoing relationship issues. For example, during this phase of treatment, one couple began to realize that the relationship became vulnerable to an affair because the partners were not making their relationship a priority in their lives. Consequently, they developed new strategies to safeguard their time together on a daily basis to maintain a stronger connection. Giving partners opportunities to work on these issues and to have small successes together can help them feel more hopeful about the relationship, and the resultant positive feelings may facilitate greater openness to examining developmental and other influences potentially contributing to vulnerability to an affair.

There are two additional issues that can become particularly salient in Stage 2. Initially one or both partners may exhibit reluctance to explore factors potentially contributing to the affair. Often partners fear that these discussions may reopen old wounds, or they may have difficulty separating "understanding" the context of the affair from "excusing" the affair, or either partner may feel that this exploration is "blaming" the victim. Consequently, it is helpful to explore partners' concerns about this process and to explain difference between understanding and excusing, as well as to examine the benefits of partners' increased understanding of each other and their relationship that they gain through this process.

Another potential difficulty in Stage 2 of treatment is the inability of either partner to experience empathy for the other. Thus, before the partners begin to explore the context of the affair, it is useful to ask questions designed to prime capacity for empathy in reaction to each other's experiences. For example, some questions may prompt partners to think about times in their own lives when they hurt others, and to reflect on their own reasons for doing so, or to think about times when they were under a great deal of stress or difficulty and consequently made poor decisions. Engaging in these exercises can help partners to gain a different perspective on each other's dilemmas and to become more open to exploring reasons for their own decisions.

Stage 3: Moving On

In the third stage of treatment, the therapist begins by integrating information obtained in previous sessions as a means of preparing the couple to reach an informed decision about how to move on from the affair. Verbal and written summaries by the therapist, along with letters written by each partner to the other, can be used to converge on a shared formulation regarding factors that contributed to the affair's occurrence. During the construction of this formulation, particular attention is paid to how the couple now understands previously violated assumptions. Much as in cognitive processing therapy for PTSD, described by Resick and colleagues (2016), any remaining questions or fears about the relationship are then addressed, and reconstructed beliefs about the relationship are evaluated. Once this goal is achieved, handouts and written exercises are used to promote partners' evaluation and discussion of their relationship's viability and its potential for change based on what they have learned about themselves and each other.

The partners should be encouraged to decide whether they wish to recommit themselves to this relationship and, if so, what changes are necessary to optimize their relationship and individual well-being. Partners may make appropriate decisions that they cannot stay with each other, yet still be able to separate and not harbor intense anger and resentment toward each other. Partners explore the process of moving on by examining the meaning of this construct as it relates to both their personal and relationship values and belief systems. In addition, the therapist and the partners discuss what aspects of the relationship may need additional attention, and how this can be accomplished to help them avoid future betrayals. In this respect, the therapy begins to move from a focus on the past to a focus on the present and future of the relationship using more common couple therapy problem-solving techniques. If the partners decide to separate, then the focus of therapy shifts to helping them do so in a way that involves the least acrimony, again, using common techniques from couple therapy (see Chapter 21 on divorce, in this volume, by Lebow). However, despite what they decide about the future of the relationship, the couple can still work to forgive each other and benefit from some specific work toward that goal. In other words, forgiveness does not require reconciling or staying together.

Although the entire process outlined in this treatment is based on our model of "forgiveness" (Gordon & Baucom, 1998), this concept is not introduced to the couple until near the end of the treatment, unless the couple uses this term comfortably earlier in the therapy. Mentioning forgiveness to someone who has recently been betrayed and is now deeply hurt or angry at the partner is unlikely to elicit a positive response. However, introducing this concept at a later point in the treatment, when anger often has decreased and the person's understanding of the betrayal has increased, is more likely to have a successful outcome, and the injured partner is likely to be more willing to consider this possibility. During the discussion of forgiveness, four basic points are covered: (1) a description of the forgiveness model, (2) common beliefs about forgiveness, (3) consequences of forgiving or not forgiving, and (4) blocks to forgiving and moving on. The description of the forgiveness model is presented in terms of its similarity to the process of exploration that the partners have just completed, and they are informed that by acknowledging and exploring the impact of the betrayal, and the reasons and context behind the betrayal, they may already have taken significant steps toward being able to forgive. Partners are then encouraged to examine and evaluate their beliefs about forgiveness in comparison to the definition of forgiveness presented to them in the treatment. For example, often couples report difficulty with forgiveness out of beliefs that forgiving the partner is "weak" or is equivalent to saying that what happened is acceptable or excusable. Challenging this belief by presenting couples with the definition of forgiveness described earlier, and by allowing that people may forgive but still appropriately hold partners responsible for their behaviors, may result in a new conceptualization of forgiveness that feels more possible for couples to achieve.

However, if these discussions do not help the couple feel more open to forgiveness, then the therapist may wish to help the couple evaluate the consequences of not forgiving. For example, research indicates that continual anger and bitterness can have a detrimental effect on individuals' physical and emotional health (e.g., Seybold, Hill, Neumann, & Chi, 2001) and on relationships with their children and future relationships (e.g., Riek & Mania, 2012). The therapist should avoid communicating to partners that they should or must always forgive. Indeed, some research indicates that immediate forgiveness in abusive relationships may lead individuals to stay in or return to unhealthy situations (e.g., Gordon, Burton, & Porter, 2004). In these cases, forgiveness before the injury is rectified or stopped may be premature or inappropriate. Such individuals may need encouragement to admit fully to themselves that this abuse is destructive and that they have a right to be angry. This anger may serve as a motivating force to help them make important changes in their relationships. Furthermore, some partners may not be ready to forgive. In such cases, the therapist should examine what purposes the anger and negative affect, behaviors, and cognitions still serve for the couple and then, based on what is uncovered, appropriately address these barriers to moving on.

MECHANISMS OF CHANGE

Several aspects of this treatment are necessary for the couple's recovery and change. Most importantly, given that much of this treatment is based on a theoretical understanding that disrupted assumptions about self, partner, and relationship are what make an affair traumatic, a crucial ingredient in recovering from an affair is partners' ability to reconstruct their views about themselves, each other, and their relationships in ways that promote feelings of security and ability to interact effectively with one another in the present and future. Even if the partners decide to end their relationship, this reconstruction process is critical for ensuring that the partners not allow the affair to poison their co-parenting relationship (if they have children together) and not experience lasting effects from the affair in future relationships. What partners learn about themselves and their relationships in this treatment can help protect them from making similar mistakes in future relationships.

Furthermore, the insights that partners gain into each other's developmental histories can promote greater empathy for each other in their struggles to restore intimacy and security in their relationship if they decide to stay together. Research indicates that empathy is an important mediating factor in persons' ability to forgive and move beyond interpersonal betrayals (e.g., Chi et al., 2019; Riek & Mania, 2012). Thus, this treatment pays particular attention to the information the partners have gained about each other and their acknowledgments of vulnerability to promote an atmosphere of mutual support and empathy.

The therapist's ability to remain neutral and to frame the couple's issues systemically is a factor in most couple treatments. However, this ability takes on particular salience in any treatment dealing with infidelity. Infidelity can elicit a broad range of negative reactions from persons in the general community, and therapists are not necessarily immune to such reactions—particularly if they have experienced infidelity or similar relationship betrayals themselves. Therapists need to be attuned to the potential impact of their own experiences with infidelity and the barriers to effective work that are created by unresolved issues (Vossler & Moller, 2014). A critical ingredient of this therapy is a therapist who remains empathic and morally nonjudgmental toward both partners, while acknowledging the destructive impacts of the affair. Indeed, involved partners, in particular, often indicate that the impartiality shown by their couple therapist using this treatment model was a crucial factor in their decision to fully engage in the treatment, as well as in their experience of safety in the sessions.

Several couple factors likely moderate the success of the treatment. Although distinct from curative or mediating mechanisms, they are factors that can affect the outcomes of the treatment. The first major factor is the personalities or enduring traits of the partners. One of the most striking individual differences that affects the recovery process is the presence of certain types of psychopathology in either member of the couple, particularly the presence of antisocial or narcissistic personality traits (e.g., Atkins et al., 2005). As with most treatments, these characteristics are poor prognostic indicators for successful recovery due to the extreme self-focus in such individuals. Furthermore, when either partner has had preexisting difficulties with emotional fragility or emotion regulation, or a fragile sense of self-worth prior to the affair because of other abandonment or negative relationship experiences, the treatment may be less effective or may progress more slowly. In essence, when the affair triggers or builds on preexisting vulnerabilities, treatment is more difficult. For partners or couples with emotion regulation difficulties, the strategies described in Stage 1 can be helpful. Discomfort with or avoidance of affect is another individual difference that complicates treatment because feelings of hurt, anger, depression, and anxiety related to the betrayal need to be processed between partners.

Issues related to commitment levels in the relationship may be pertinent in two ways. Partners' initial levels of commitment to their relationship when they enter therapy are important factors in their ability to engage in the treatment. However, the issue of commitment in the treatment of infidelity may also be related to a developmentally based fear of intimacy or feelings of being "trapped" in an enduring relationship. Individuals with such commitment issues may desire intimate relationships and seek them out, yet fear them to such an extent that they find it difficult to feel safe in an intimate relationship, and hence pursue an affair as a "safer" alternative (Parker & Campbell, 2017). In such cases, this issue needs to be addressed directly—either during Stage 2 of this treatment or in adjunctive individual therapy.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

This treatment approach was developed explicitly to address the difficulties that couples experience following an affair. However, the affair need not be limited to a sexual relationship; as noted earlier, extradyadic *sexual* contact is not always necessary for one partner to feel that the other's involvement with someone outside the primary committed relationship breaks the agreed-upon commitment to monogamy in the relationship contract. In addition, because this model is based on both the traumatic response literature and the interpersonal forgiveness literature, it can be tailored to treat couples recovering from other, severe interpersonal betrayals that are not classified as affairs. Any event that severely disrupts either partner's assumptions regarding the relationship has the potential to cause great emotional distress and destroy the experience of safety within the relationship (e.g., perceived abandonment, financial deception, violations of pledges to sobriety). These disruptive events often require the same therapeutic process described in this chapter.

Although this approach can be used to address myriad types of relationship betrayals, it is not well suited for couples in which the involved partner denies having participated in an affair, nor is it useful when neither partner feels betrayed. This approach has been designed specifically to address recovery from betrayal, and it is doubtful that a couple would benefit from this therapy if neither partner felt that such a betrayal had taken place. Thus, a couple who espouses an open relationship but is struggling with issues unrelated to boundaries with a third person might benefit from other appropriate foci within treatment.

Empirical Support

Initial findings provide empirical support for this treatment approach. A replicated case study was conducted with six couples in which a partner had participated in an affair (Gordon, Baucom, & Snyder, 2004). Prior to treatment, the majority of injured partners had significantly elevated symptoms of depression and PTSD. Furthermore, the couples reported low levels of commitment, trust, and empathy, and clinically elevated levels of marital distress; in addition, all injured partners reported difficulties forgiving the affair. After participating in the treatment described in this chapter, gains were greatest for injured partners in the domains specifically targeted by this treatment. Responses on the Forgiveness Inventory (Gordon & Baucom, 2003) demonstrated that feelings of anger, revenge, and avoidance were greatly reduced following treatment, whereas feelings of understanding, release, and inner peace increased. There also were substantial decreases in symptoms associated with PTSD and depression. The general marital distress of injured partners also decreased, but there was less of a decrease for the involved partners (who initially reported less marital distress than did the injured partners). Furthermore, although this study found that the treatment was most advantageous for the injured partners, it also was beneficial for the involved partners. Upon completing the treatment, involved partners expressed that the treatment was critical to their improvement in several domains, including a better understanding of why they participated in the affair and increased ability to tolerate their partners' initial negativity and subsequent flashback reactions.

Effect sizes in this study were found to be moderate to large and were comparable to effect sizes of empirically validated couple therapies not created specifically to target the difficulties couples experience following an affair (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Moreover, Baucom, Gordon, Snyder, Atkins, and Christensen (2006) found that the infidelity-specific intervention outlined in this chapter had larger effect sizes for decreasing global individual symptoms and depression in both the involved partners and injured partners when compared to integrative behavioral couple therapy (IBCT), although the two treatments produced comparable reductions in global marital distress for injured partners. Finally, in a separate randomized clinical trial of a German adaptation of this treatment, Kröger, Reibner, Vasterling, Schütz, and Kliem (2012) found that the treatment model described here produced significant reductions in posttraumatic anxiety for both partners and significant improvements in depression and relationship satisfaction for involved partners.

CASE ILLUSTRATION

We have provided numerous, detailed clinical illustrations of this treatment approach elsewhere. The interested reader is referred particularly to the clinician's manual (Baucom et al., 2009) describing multiple cases, including more complicated instances when the affair involves outside persons in trusted positions, hierarchical relationships, enduring consequences such as pregnancy or STI, or features of unusual length or breadth. In the case illustration that follows, we've chosen to present a couple with whom the treatment at times became particularly challenging because of one or the other partner's struggles with significant individual issues they were initially unprepared or unable to address in conjoint sessions. While explicitly less typical than the modal application of this treatment, the use of individual sessions with this case serves a valuable illustration of a flexibly administered couple therapy that retains capacity to integrate individual sessions while retaining a core couple-based orientation. As described earlier in the chapter, issues regarding the confidentiality of these sessions should be handled carefully, and the therapist should watch for any signs of a ruptured or split alliance that might occur as a result of these sessions.

Greg and Julia were referred to one of us (KCG) for couple therapy by a local therapist who had been seeing them for 9 months but was soon retiring. When they presented for treatment, it was clear that the couple was still in a state of relative crisis after Greg's discovery of Julia's affair, with Julia regularly threatening to leave their relationship. The previous therapist reported that she had primarily focused on containing their affect and controlling the couple's conflicts during sessions. She also expressed some concern about Julia's ability to regulate her emotions and wondered about her having a personality disorder. Neither member of the couple had ever had individual therapy, and this had been their first time in couple therapy.

The current therapist (KCG) conducted an initial conjoint assessment and two separate individual assessments with the partners. In the conjoint meeting, they discussed the current state of the couple's relationship. Both partners reported experiencing intense and prolonged conflict followed by periods of silence and withdrawal. They had been married 20 years at the time of the affair. They had married when they were both in college, and Julia believed that they might have married too young. Greg was attracted to Julia's energy and her organization, and he liked the fact that she kept him "in line." Julia found Greg extremely attractive and felt that they could talk about anything. They both said they initially had a great deal of fun together and that the relationship just felt "easy," unlike their previous relationships.

However, as their relationship progressed, both Greg and Julia accepted extremely demanding jobs that required a great deal of their attention. Julia was required to travel a great deal for her job; Greg worked in a male-dominated profession that demanded long hours and led to socializing after work at bars. As a result, they did not have much time or energy to prioritize their relationship, and they drifted into a life that was more like "parallel play" than a true partnership or romance. During conflicts, Julia tended to express her opinions passionately, whereas Greg would respond once or twice, then shut down. However, Greg said that since the affair, he found himself getting much angrier than he had ever been before and was more likely to escalate in response to Julia. Julia was ambivalent about continuing the marriage but felt trapped because she was afraid to be alone. Greg was more invested in the marriage, but his hurt and anger were all-consuming. Both were isolated and had few friends or sources of support.

The therapist also collected information about their respective families of origin during the individual meetings. Greg was the oldest of four children and was the "golden boy." What little money his family had went to supporting his education at the expense of his siblings; he consequently felt that he had to make it up to his family in return by being a financial success. Julia's father was a very successful businessman who was consumed by his career. Her family had a great deal of money but very little warmth and interaction. Julia was able to attract her parents' attention only when she evidenced high achievement in her schoolwork or in athletics. Julia also stated she created tension in the family by being "too emotional." Thus, both Greg and Julia had strong incentives to be successful professionally and financially.

Julia's affair came to light when she decided to leave Greg for the affair partner. Greg followed her to her affair partner's house and confronted her. During the confrontation, he alternately raged at her and begged her to come home. Julia was surprised at the strength of his response. She stayed with the affair partner for a couple of months but remained in touch with Greg during that time, and she eventually returned home. Julia had not expected Greg to care that she had left him, and his response made her question whether she was making the right decision. When she decided to try to make their marriage work, they sought out couple therapy.

The immediate goals for therapy were to contain the conflict and help the couple to clarify their ambivalence about their relationship. Greg would initiate conversations with Julia about the affair, which would eventually escalate and leave them both angry and hurt. Similarly, in the sessions, the therapist found exploring the affair or the couple's reaction to it to be extremely difficult. Julia would either withdraw or escalate, and Greg would follow her lead and enact similar behaviors. This pattern also made Stage 1 work complicated because when the therapist focused on Greg's feelings about the affair, Julia would lash out at him. Greg wrote his letter carefully with the therapist's help and gave it to Julia before their session, so that she might have time to process it. However, when Julia arrived, it was clear that she was angry. As Greg read the letter aloud, she launched into an angry outburst about his selfishness. When the therapist intervened to help Julia regain her equilibrium, she retreated into an angry silence, so the therapist decided to explore Julia's experience at that moment.

THERAPIST: I have a feeling that you are angry with me.

JULIA: I think you don't get it. Everyone sees me as a monster because "women don't cheat." What is wrong with me that I cheated? That's what I think everyone thinks; that I'm a bad person. But they don't get all the things that led up to it. They just see him as the victim. He's not the victim. He's not. I can't stand it that I'm the bad one here.

THERAPIST: Do you think *I* see you as the bad one here?

JULIA: Yes—no—I don't know. You keep focusing on his experience of my cheating. I haven't been able to talk about my feelings about things. I think you do see me as the bad guy.

Efforts by the therapist in this session to reassure Julia that she did not see her as a "bad guy" and to restore a collaborative therapeutic alliance had little impact on reducing Julia's belief that the therapist—"just like everyone else"—had villainized her. At that point, the therapist realized she needed to do more work on her alliance with Julia, which she decided would best be done without Greg present to trigger Julia's anger and shame. Consequently, with Greg's permission, she set up an individual session with Julia. In that session, Julia talked about painful early events in their marriage. First, Greg had had a one-night stand in the first year of their marriage that the couple just "shoved under the rug." Second, Julia had had several miscarriages, and Greg repeatedly refused to discuss her grief or any plans to address their infertility. She saw Greg as selfish and unfeeling, and she felt alone and bereft, so she retreated into her work. When a work colleague started showing her more warmth and empathy, she was vulnerable to his attentions.

The therapist was able to express understanding and empathy with Julia's struggles and thus repaired the rupture. They were also able to talk about Julia's shame about her affair and Julia's own fear that *she* was a bad and selfish person. Together they talked about the difference between shame, the perception that "I am bad" and the concomitant desire to hide or lash out, and guilt, the perception that "I engaged in bad behavior" and the desire to fix it or make up for it. Julia's shame and her own hurt and anger were making it difficult for her to stay present with Greg's pain and do an appropriate repair, so the therapist and Julia decided on a two-pronged approach in which Julia would write her own letter regarding Greg's betrayals of her that she could read after they had successfully processed Greg's letter. Julia and the therapist agreed to work together to help her reframe her self-perceptions from "I am bad person" to "I made a mistake in how I handled my pain and I can do better." The therapist was able to convey to Julia that she heard Julia's own sense of betrayal and, in this setting without Greg present, Julia was able to see the wisdom of how being open to Greg's hurt could repair her own mistake, and she agreed to be patient until they were both ready to explore her reasons for the affair in Stage 2. After this meeting, the couple was able to successfully process Greg's letter. Julia reflected his experience well and expressed appropriate remorse, which she had failed to do up until that point. Greg was relieved by this experience and reported that the tension in the home was greatly reduced.

However, even with this reduction, as the therapy progressed into Stage 2 work, Julia and Greg still struggled to productively discuss their relationship patterns as they started exploring the roots of the affair. The couple did some good work linking their current struggles to their earlier development histories; both Julia and Greg were able to develop empathy for each's other "workaholism" when they were able to see that they both used achievement as a means to feel worthy of love and care, and they developed insight into how their families of origin fostered those beliefs. They also were able to make steps toward challenging those beliefs by taking time to deliberately rest and reconnect. However, Julia remained highly sensitive whenever her role in their general conflict patterns was discussed, so the therapist decided to address this issue more directly.

THERAPIST: Tell me more about what happens when you two get into an argument right now? Give me an example that happened recently.

JULIA: Well, on Wednesday, he came home and he went straight to his man-cave. I waited a bit to see if he'd come back up, but he didn't. So I got upset and followed him down there.

GREG: I had a long day and I needed time to relax . . .

JULIA: You could have at least said "hello" to me—that was just like you were before!

GREG: Before what?

JULIA: Before you found out about the affair—you were never there, never present, and we are just going back to the way we were before and I can't handle that. I can't do it.

THERAPIST: Julia, it sounds like when he headed down to the basement, it reminded you of all the times you've felt alone in your relationship, is that right?

JULIA: Of course, that's right, that's what I'm saying, he's just going back to the way he's always been.

THERAPIST: So you were feeling alone again, and I wonder if you were also a bit hurt that he didn't acknowledge you?

JULIA: Maybe . . . but I was mostly angry. He always disappears on me, and I'm sick of it and won't go back.

THERAPIST: So what did you do with those feelings?

JULIA: I decided I wouldn't let him get away with it, and I went down and let him know it. I'm not going to be taken for granted anymore. I'm not going let him step on me.

GREG: I'm not stepping on you—I just wanted a break and a drink for God's sake.

JULIA: You could have said hello . . .

THERAPIST: (*interrupting and gaining Julia's attention*) Julia—look at me—thank you—can you tell me what you noticed happened with Greg after you let him have it?

JULIA: First he yelled at me to leave him alone, and then he clammed up.

THERAPIST: It sounds like that pattern that we have talked about before: that when you feel dismissed you get really angry so you can't be ignored, and he withdraws and hunkers down until you go away.

JULIA: (*crosses her arms, glares at Greg and therapist*) I don't have to take this. I was already at the end of my rope. (*Gets up and leaves.*)

The next week, Julia refused to come back into therapy—and the couple therapy was at high risk for ending. With Julia's consent, the therapist met separately with Greg to discuss his and Julia's patterns of escalation highlighted in the previous conjoint session. They discussed how he typically responded to Julia's anger by avoiding her and becoming "invisible," which they traced back to his hopelessness at ever feeling heard in his family of origin. Changing the pattern required him to take some risks and be present with Julia even in the face of her anger, to not "ghost" her but to try and stake out ground for himself in as compassionate a way as possible. The therapist also reminded him to take time-outs when emotions were running too high.

Following this session with Greg, the therapist was able to persuade Julia to come back for an individual session as well, and they spent that session repairing the rupture by exploring why Julia was "at the end of her rope." Julia's frustration was that she and Greg were slipping back into preaffair patterns in which they led parallel lives. She was afraid they were going back to that lonely existence where Greg disappeared on her and she was left alone to keep things running. The therapist was also able to explore why Julia had been so upset with the therapist's conceptualization of their pattern being "go big–go small." After Julia's initial resistance, the therapist reflected that she wondered if that formulation was too close to what Julia had experienced as a child when her family told her that her emotions were too much. Julia teared up and acknowledged that was her experience, both with the therapist and with Greg. The go-big and go-small formulation left her understandably feeling like a bully. The therapist and Julia were able to gently discuss how Julia's passion was both her greatest gift and also could be overwhelming to Greg and might not give him much space to breathe. The therapist tried a reformulation of the pattern, suggesting the Ghost and the Machine, where Greg "ghosted" Julia and Julia suppressed her emotions, particularly the more vulnerable ones, until they burst out with a high intensity to get people's attention, which Julia felt accurately captured the pattern.

Following these two individual sessions, both partners were encouraged by having achieved expanded understanding of their own and each other's conflict patterns, and both agreed to resume conjoint sessions. The couple became more productive in exploring the context for the affair and their problematic interactions. Greg was able to listen to Julia read her letter regarding her hurt and feelings of abandonment due to his one-night stand and his refusal to discuss her miscarriages. He owned how his early experiences of being punished for showing emotions in his family led to him learning the lesson that you just "put your head down and got on with it" when things were difficult, which was how he still handled intense feelings; however, he now realized that this strategy impeded intimacy and closeness with his wife and kept them from addressing their problems effectively. He began to experiment with staying more present in their interactions and finding ways to express his own feelings during arguments, although this was difficult for him.

The couple worked hard during Stage 2 to explore contributing factors to Julia's affair. Addressing their respective vulnerabilities and developing empathic responses were more difficult than focusing on external stressors but, over time and with considerable effort, they began to construct a shared understanding of risk factors from multiple sources—some more current, others more from their respective histories. Eventually, believing they had achieved an adequate overall formulation, both Greg and Julia felt more prepared to have explicit conversations about how to move on—and treatment transitioned into Stage 3.

As the couple moved into Stage 3 work, it became clear that Greg had his own shame around his wife's affair. He told one of his work colleagues about the affair early in the process, with the unfortunate consequence that it became widely known. He was subsequently unwilling to take Julia with him to the holiday party, which led to her discovering that Greg had not told his colleagues that he had reconciled with her. Julia was hurt and angry but able to express those emotions to Greg clearly without attacking him. Greg, in turn, was defensive and unwilling to acknowledge her pain. Thus, the therapist decided to explore his reactions further.

THERAPIST: Greg, tell us what it was like to have your colleagues know about the affair.

GREG: Humiliating. I know what I would have thought of someone in that situation before the affair, and I know they are thinking that about me.

THERAPIST: What would you think about that person before the affair?

GREG: That he was weak and stupid, and likely to get fooled again.

JULIA: Do you think that about yourself? Do you think that about me—that I would do this again?

GREG: I don't know—maybe. Sometimes I feel confident in you—but sometimes I think you only stay with me because you felt guilty and not because you really want to—and sometimes I think I should have ended it all and not have to be reminded of the affair all the time.

JULIA: I knew it—I knew that it's all you see when you look at me. Why did we even do this?

GREG: No—I don't mean that. That's not all I see.

THERAPIST: Wait a minute—Julia, I know that hurt you when Greg said that—and, of course, you feel that way. And I think this might be a moment when that shame spiral we discussed is grabbing you—you are feeling awful about yourself because Greg feels this way. Is that at all possible?

JULIA: Maybe . . .

THERAPIST: Can you step back from that for a moment and hold it—we will come back to that. Can you remind yourself that in these moments, you can make a repair by turning toward Greg and hearing what he has to say without judging it?

JULIA: I can try.

The therapist then began to formulate with Greg that he might be in his own shame spiral, labeling himself as spineless and thus avoiding and hiding from the situations that triggered that feeling. Instead, at this moment, she encouraged him to turn toward the feeling and evaluate whether the process of forgiving his wife was weak or required strength. They also talked about a couple in his church that he admired, who had also gone through an affair and were able to rebuild their marriage. He tried on the image of his own marriage being that kind of model for other couples who struggle. The therapist also encouraged him to check out his belief that Julia did not truly want him and saw him as weak. Julia was able to reassure him that her feelings for him had changed as they had worked together over the last year, and that she respected him and felt closer to him than she ever had.

Eventually, this couple was able to move forward from the affair, and it no longer dominated their lives or their conflicts. They still struggled from time to time with their former less adaptive patterns of engaging conflict, and the therapist acknowledged with them that this pattern would likely be a continual challenge for the two of them because it was a naturally occurring consequence of their different personalities and histories; however, this pattern did not have to dominate their interactions, and they could find ways to sidestep it or reduce its toxicity even by just recognizing when it was occurring. They were able to taper their sessions to once a month and eventually transitioned to once per year as a booster. Greg was able to say that even though he would never have wished this experience on his worst enemy, it allowed them to finally get a relationship that was more like what they both wanted, and he was grateful for that possibility. Recovery from an affair is not easy and requires both partners' commitment and willingness to be vulnerable; thus, many couples are unable to negotiate the challenges necessary to complete this process. However, when they do the work, they are often rewarded by significant posttraumatic growth and richer, deeper relationships.

CONCLUDING COMMENTS

Sexual and emotional involvements outside of one's committed relationship occur with high frequency and have well-documented adverse consequences for individual partners and their relationship, potentially extending to their children and others in their intimate support network, such as family and closest friends. Couple therapists recognize infidelity as being among the most difficult issue to treat—not only because of the intense negative partner interactions that typically accompany disclosure or discovery of an affair, but also because most couple therapies do not directly address the traumatic aspects of interpersonal betrayal.

The treatment described here for helping couples struggling with issues of infidelity comprises an integrative approach combining both cognitive-behavioral and insight-oriented strategies, as well as evidence-based strategies from the trauma and forgiveness literatures. Dealing with an initial destabilizing impact, exploring contributing factors as a mechanism for restoring security, and ultimately reaching informed decisions about how to move forward form the foundation of this approach. Although designed primarily as a couple-based intervention, this overarching conceptual framework can be adapted to individuals working to recover from infidelity in individual therapy, as well as incorporating individual sessions into the conjoint treatment when required to address specific impasses.

Finally, although developed specifically as a treatment for recovery from infidelity, the framework and strategies described here may be modified and generalized to other relationship betrayals (e.g., relapses or violations of sobriety from alcohol or other substances) in which managing traumatic impact, exploring multiple and diverse contributing factors, and considering issues related to forgiveness and moving forward require a similar sequential, stage-based approach.

SUGGESTIONS FOR FURTHER STUDY

Allen, E. S., Atkins, D. C., Baucom, D. H., Snyder, D. K., Gordon, K. C., & Glass, S. (2005). Intrapersonal, interpersonal, and contextual factors in engaging in and responding to infidelity. *Clinical Psychology: Science and Practice, 12,* 101–130.

Baucom, D. H., Snyder, D. K., & Gordon, K. C. (2009). *Helping couples get past the affair: A clinician's guide.* New York: Guilford Press.

Gordon, K. C., & Baucom, D. H. (1998). Understanding betrayals in marriage: A synthesized model of forgiveness. *Family Process, 37,* 425–450.

Hertlein, K. M., & Weeks, G. R. (2007). Two roads diverging in a wood: The current state of infidelity research and treatment. *Journal of Couple and Relationship Therapy, 6*(1–2), 95–107.

Snyder, D. K., Baucom, D. H., & Gordon, K. C. (2007). *Getting past the affair: How to cope, heal, and move on—together or apart.* New York: Guilford Press.

REFERENCES

Allen, E. S., & Atkins, D. C. (2012). The association of divorce and extramarital sex in a representative US sample. *Journal of Family Issues, 33,* 1477–1493.

Allen, E. S., & Baucom, D. H. (2005). Dating, marital, and hypothetical extradyadic involvements: How do they compare? *Journal of Sex Research, 43,* 307–317.

Atkins, D. C., Eldridge, K. A., Baucom, D. H., & Christensen, A. (2005). Infidelity and behavioral couple therapy: Optimism in the face of betrayal. *Journal of Consulting and Clinical Psychology, 73,* 144–150.

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. E. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach.* Abingdon, UK: Routledge.

Baucom, D. H., Gordon, K. C., Snyder, D. K., Atkins, D. C., & Christensen, A. (2006). Treating affair couples: Clinical considerations and initial findings. *Journal of Cognitive Psychotherapy, 20,* 375–392.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66,* 53–88.

Baucom, D. H., Snyder, D. K., & Gordon, K. C. (2009). *Helping couples get past the affair: A clinician's guide.* New York: Guilford Press.

Cano, A., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of nonspecific depression and anxiety. *Journal of Consulting and Clinical Psychology, 68,* 774–781.

Chi, P., Tang, Y., Worthington, E. L., Chan, C. L. W., Lam, D. O. B., & Lin, X. (2019). Intrapersonal and interpersonal facilitators of forgiveness following spousal infidelity: A stress and coping perspective. *Journal of Clinical Psychology, 75,* 1896–1915.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach.* Washington, DC: American Psychological Association.

Glass, S. P. (2002). Couple therapy after the trauma of infidelity. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 488–507). New York: Guilford Press.

Glass, S. P. (2003). *Not "just friends": Protect your relationship from infidelity and heal the trauma of betrayal.* New York: Free Press.

Gordon, K. C., Amer, Z., Lenger, K. A., Brem, M. J., Baucom, D. H., & Snyder, D. K. (2019). Forgiveness and the dark side of intimate relationships: Infidelity, intimate partner violence, and divorce. In E. L. Worthington & N. G. Wade (Eds.), *Handbook of forgiveness* (2nd ed., pp. 153–163). New York: Routledge.

Gordon, K. C., & Baucom, D. H. (1998). Understanding betrayals in marriage: A synthesized model of forgiveness. *Family Process, 37,* 425–449.

Gordon, K. C., & Baucom, D. H. (2003). Forgiveness and marriage: Preliminary support for a measure based on a model of recovery from a marital betrayal. *American Journal of Family Therapy, 31,* 179–199.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2000). The use of forgiveness in marital therapy. In M. E. McCullough, K. I. Pargament, & C. E. Thoresen (Eds.), *Forgiveness: Theory, research, and practice* (pp. 203–227). New York: Guilford Press.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2004). An integrative intervention for promoting recovery from extramarital affairs. *Journal of Marital and Family Therapy, 30,* 213–231.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2008). Optimal strategies in couple therapy: Treating couples dealing with the trauma of infidelity. *Journal of Contemporary Psychotherapy, 38,* 151–160.

Gordon, K. C., Burton, S., & Porter, L. (2004). Predicting the intentions of women in domestic violence shelters to return to partners: Does forgiveness play a role? *Journal of Family Psychology, 18,* 331–338.

Greenan, D. E., & Tunnell, G. (2003). *Couple therapy with gay men.* New York: Guilford Press.

Kaighobadi, F., Shackelford, T. K., & Archer, J. (2009). Suspicions of female infidelity predict men's partner-directed violence. *Behavioral and Brain Sciences, 32,* 281–282.

Kaplanova, A., & Gregor, A. (2019). Guilt- and shame-proneness and their relation to perceptions of dating infidelity. *Journal for Basic Research in Psychological Sciences, 61*(3), 145–158.

Kröger, C., Reibner, T., Vasterling, I., Schütz, K., & Kliem, S. (2012). Therapy for couples after an affair: A randomized-controlled trial. *Behaviour Research and Therapy, 50,* 786–796.

Labreque, L. T., & Whisman, M. A. (2017). Attitudes toward and prevalence of extramarital and descriptions of extramarital partners in the 21st century. *Journal of Family Psychology, 31,* 952–957.

Martell, C. R., & Prince, S. E. (2005). Treating infidelity in same-sex couples. *Journal of Clinical Psychology, 61,* 1429–1438.

Parker, M. L., & Campbell, K. (2017). Infidelity and attachment: The moderating role of race/ethnicity. *Contemporary Family Therapy, 39,* 172–183.

Previti, D., & Amato, P. R. (2004). Is infidelity a cause or a consequence of poor marital quality? *Journal of Social and Personal Relationships, 21,* 217–230.

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive processing therapy for PTSD: A comprehensive manual.* New York: Guilford Press.

Riek, B. M., & Mania, E. W. (2012). The antecedents and consequences of interpersonal forgiveness: A meta-analytic review. *Personal Relationships, 19,* 304–325.

Rietmeijer, C. A., Bull, S. S., & McFarlane, M. (2001). Sex and the Internet. *AIDS, 15,* 1433–1434.

Roberts, S. T., & Flaskerud, J. H. (2008). Traditional Mexican immigrant women and distress over infidelity. *Issues in Mental Health Nursing, 29,* 913–916.

Roos, L. G., O'Connor, V., Canevello, A., & Bennett, J. M. (2018). Post-traumatic stress and psychological health following infidelity in unmarried young adults. *Stress and Health, 35,* 468–479.

Schneider, J. P. (2002). The new "elephant in the living room": Effects of compulsive cybersex behaviors on the spouse. In A. Cooper (Ed.), *Sex and the Internet: A guidebook for clinicians* (pp. 169–186). New York: Brunner-Routledge.

Scuka, R. F. (2015). A clinician's guide to helping couples heal from the trauma of infidelity. *Journal of Couple and Relationship Therapy, 14,* 141–168.

Seybold, K. S., Hill, P. C., Neumann, J. K., & Chi, D. S. (2001). Physiological and psychological correlates of forgiveness. *Journal of Psychology and Christianity, 20,* 250–259.

Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couple therapy. *Clinical Psychology: Science and Practice, 6,* 348–365.

Snyder, D. K., Balderrama-Durbin, C., & Fissette, C. L. (2012). Treating infidelity and comorbid depression: A case study involving military deployment. *Couple and Family Psychology: Research and Practice, 1,* 213–225.

Snyder, D. K., Baucom, D. H., & Gordon, K. C. (2007). *Getting past the affair: How to cope, heal, and move on—together or apart.* New York: Guilford Press.

Snyder, D. K., & Doss, B. D. (2005). Treating infidelity: Clinical and ethical directions. *Journal of Clinical Psychology, 61,* 1453–1465.

Snyder, D. K., Gasbarrini, M. F., Doss, B. D., & Scheider, D. M. (2011). Intervening with military couples struggling with issues of sexual infidelity. *Journal of Contemporary Psychotherapy, 41,* 201–208.

Snyder, D. K., & Mitchell, A. E. (2008). Affective–reconstructive couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 353–382). New York: Guilford Press.

Softas-Nall, B., Beadle, M., Newell, J., & Helm, H. M. (2008). Spousal disclosure of extramarital relationships: Attitudes of marriage and family therapists. *Family Journal, 16,* 328–337.

Vossler, A. (2016). Internet infidelity 10 years on: A critical review of the literature. *Family Journal, 24,* 359–366.

Vossler, A., & Moller, N. P. (2014). "The relationship past can't be the future": Couple counselors' experiences of working with infidelity. *Sexual and Relationship Therapy, 29,* 424–435.

Weeks, G. R., & Treat, S. R. (2001). *Couples in treatment: Techniques and approaches for effective practice* (2nd ed.). New York: Brunner-Routledge.

Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology, 11,* 361–366.

Worthington, E. L., & Wade, N. G. (Eds.). (2019). *Handbook of forgiveness* (2nd ed.). New York: Brunner-Routledge.

CHAPTER 19

Couple Therapy and Sexuality

Kathryn S. K. Hall and Daniel N. Watter

BACKGROUND

When William Masters and Virginia Johnson published their ground-breaking book *Human Sexual Inadequacy* in 1970, it heralded a new approach to the understanding and treatment of sexual problems, essentially laying the groundwork for the new field of sex therapy. Their earlier work, *Human Sexual Response* (Masters & Johnson, 1966), built on the foundation of others who strove to understand human sexuality from a scientific rather than a moralistic or religiously based perspective (Ellis, 1927; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). These pioneering sex researchers not only noted the diversity of human sexual behavior but also challenged societal prohibitions and argued in favor of tolerance and rationality.

Masters and Johnson (1966, 1970) sidestepped the issue of sexual diversity, studying the physiology of human sexual behavior in a laboratory setting. Healthy, primarily young, middle-class, able-bodied, White, heterosexual, cisgender men and women engaged in sexual activity (masturbation or penile–vaginal intercourse), while Masters and Johnson recorded indices of arousal such as heart rate and skin temperature. The data from these studies formed the basis of what came to be considered the *universal* human sexual response, divided into periods of increasing and then plateauing arousal, orgasm, and resolution (the diminishing of the arousal response). Along with painful intercourse, and with the addition of a desire phase (Kaplan, 1977; Leif, 1977), Masters and Johnson identified sexual dysfunctions as problems occurring within the stages of their model and identified performance anxiety as the predominant root cause. The diagnoses of the sexual dysfunctions have remained virtually unchanged over the years and correspond roughly to low sexual desire, erectile dysfunction (ED), inability to orgasm, premature ejaculation (PE), delayed ejaculation, and fear/pain with intercourse.

Initially, sex therapy focused on alleviating performance anxiety to improve sexual function, with behavioral and cognitive-behavioral techniques forming the mainstay of treatment. Masters and Johnson famously invoked the understanding that sexual problems are *couple* problems, even if the dysfunction is manifest only in one of the partners. Sex therapy, as they defined it, was couple therapy conducted by a male and female co-therapist team. In their clinic, patients stayed for 2 weeks to work daily with their co-therapists and were given "homework" assignments to do on their own and report back to their therapist team. Masters and Johnson reported high success rates in treating sexual dysfunctions which, while never replicated, are perhaps at least partly responsible for the continuing public popularity of sex therapy today.

Although Masters and Johnson are still household names, the practice of sex therapy has greatly changed. The vast majority of people cannot afford the time or expense of a 2-week stay at a sex therapy clinic. Now sex therapy is typically practiced by one therapist, while still focusing on the couple as the patient (although individuals are seen as well). Importantly, there is now the relatively new field of sexual medicine, thanks in part to pharmaceutical interest in and funding for the treatment of sexual dysfunction. Medications to improve erections, of which Viagra was only the first, were followed by medications to increase sexual interest and desire in women and to delay ejaculation in men, pelvic floor physical therapy techniques, as well as medications and surgery used to address sexual pain, while shock wave therapy is being used and investigated for the treatment of ED and surgery is still performed to replace malfunctioning penile physiology with inflatable or mechanical implants. Sexual function problems are now most often addressed by an interdisciplinary approach involving a collaboration of sex therapy and sexual medicine. Most importantly, sex therapy has expanded its scope of practice beyond dysfunctions, acknowledging the diversity of sexual expression ignored by embracing a *universal* sexual response model, and understanding that given the diversity of sexual expression there will be a similar diversity of sexual problems. This expanded scope of practice also extends to a focus on improving or enhancing the experience of *functional* sex. Sex therapy interventions are now frequently used to promote greater sexual awareness, improve sexual responsiveness, and enhance couples' enjoyment of their sexual experiences.

Sex therapy's current position regarding diversity is not without controversy. While philosophically, sex therapists describe their approach to understanding sexuality and sexual behavior as "sex-positive" (i.e., sex therapists view sex as a beneficial aspect of identity and life and they advocate for freedom of sexual expression), there have been and are limits. Recall that Masters and Johnson's research was focused on heterosexuals and described one pattern of response based on heterosexual behavior—yet that model has, until recently, been used as the standard by which all sexual functioning is measured. While clinically, sex therapists are working with couples from the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) and polyamorous communities, sex research and diagnosis lag behind. Take, for example, the heterosexually oriented diagnostic criteria for premature ejaculation in the recent text revision of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022, p. 501): "a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within about one minute following vaginal penetration and before the individual wishes it." Another example involves paraphilic disorders. Again, according to DSM-5-TR, these disorders involve distress about atypical sexual interests,[1] so identified as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (p. 779). The echoes of Masters and Johnson's focus on heterosexual intercourse continue to resonate. And despite the evidence of Havelock Ellis (1927) at the turn of the previous century and reinforced by recent surveys of sexual behavior (Herbenick et al., 2017), many of the paraphilias are not so atypical after all.

A biopsychosocial model (Bancroft, 2008) now informs understanding of not only how sexuality develops but also how sexual problems arise. This model notes the important contributions of biology, psychology, relational, and sociocultural factors in the manifestation of sexual feelings and behaviors. Low sexual desire, for instance, may be influenced by hormonal factors, a history of trauma, unhappiness in a relationship, and/or societal messages that shame one for sexual interest and behavior (e.g., conservative beliefs that homosexuality is a sin). Hall and Graham (2020) have added a cultural *developmental* framework to this model, encouraging clinicians to look at patients' sexual histories as culturally influenced by the access they have to sexual partners and experiences, in addition to the internalized cultural messages they carry about sexuality. For example, the transition to active sexuality is a difficult one for a woman whose sexual education and experience has centered only on the task of guarding her virginity.

Today, sex therapy is not just a collection of techniques aimed at alleviating performance anxiety (which, after all, is anxiety about not performing according to a standard invoking normality). "Sex therapy" is best considered an umbrella term for various psychotherapeutic approaches to treating individuals and couples distressed about their sexuality and/or sexual functioning. It is also an approach for strengthening sexual bonds and enhancing pleasurable sex such that intimate connections are deepened. Some of the more recent therapeutic advances are the application of third-wave behavior therapy techniques such as mindfulness meditation (Brotto, 2018) and existential therapy approaches to sexual distress (Watter, 2022). However, what continues to distinguish sex therapy is not only its focus on improved sexual function and pleasure as treatment *goals* but also its understanding of the *meaning* of sexual symptomatology and the use of sex as a *treatment modality*.

---

[1] DSM-5-TR diagnoses of paraphilic disorders require distress or impairment related to one's sexual interests, much in the same way that ego-dystonic homosexuality replaced the diagnosis of homosexuality as a disorder. Many argue that the concept of paraphilias should be entirely removed from DSM-5-TR, and that sexual behavior involving minors or involving coercion are more properly categorized as criminal behaviors rather than mental disorders.

CORE UNDERSTANDINGS ABOUT THIS POPULATION

When couples present for sex therapy, they are most often in extreme distress. Relationships flounder when sex becomes problematic instead of pleasurable, and intimacy, not just sexual intimacy, suffers. It is often difficult to parse out whether the relationship distress is a cause or consequence of sexual problems. Sex therapy approaches this dilemma with a focus on addressing the sexual symptoms first,[2] then turning to underlying issues if the symptom focus does not alleviate the problem, or if addressing the sexual problem uncovers other difficulties.

Take the case of Monica and Andrew, who came to therapy to address Andrew's PE. Married for 3 years, they recently left apartment living in Manhattan to move into a single-family home in suburban New Jersey. The transition was difficult, and without the distractions of New York, the couple found themselves arguing more frequently and having little, if any, sex. Andrew reported that the lack of sex caused him to be short tempered, and that he ejaculated rapidly now because sex was so infrequent. Monica retorted that he had always ejaculated quickly, and that she hadn't minded it so much because she was happy, and because with more frequent sex there were at least some occasions when she was satisfied. Sex therapy focused on helping Andrew attend to his increasing arousal and gain control over the timing of his ejaculation. While Andrew made great improvements in his ability to control his ejaculation during masturbation and during times when Monica was manually or orally stimulating him, delaying his ejaculation during intercourse was difficult. Monica became increasingly distraught following these "improvements," stating that sex was all about Andrew, and not at all about her pleasure. To Andrew she said: "It's always been about you. You don't care about me and what I want at all!" The focus of therapy pivoted to the issue of Andrew failing to meet Monica's needs on many fronts. It turned out that, unbeknownst to Monica, Andrew was deep in debt, a situation that was exacerbated by the purchase of a home. Andrew shared that he felt pressured to make Monica happy, to give her everything she wanted, and it was hard for him to be honest about what he perceived to be his limitations. In more ways than just sexually, Andrew was not paying attention to his emotional state, and his focus on "pleasing" Monica was doing just the opposite.

Monica and Andrew are not alone in their experience of sexual distress. Large-scale surveys reveal that over 40% of women and about 33% of men report having experienced at least one sexual problem in the preceding 6 months (Laumann et al., 2005). These surveys can be misleading, however, because they often do not address the reasons for the sexual problem (e.g., Is the lack of desire due to the lack of an available partner?), nor do they ask about whether the problem is distressing. For example, more older women report low sexual desire, but younger women are more distressed about their lack of desire and so are more likely to present for treatment (Brotto & Velten, 2020). When only those sexual problems that cause the sufferer distress or unhappiness are counted, the rate of reported dysfunction falls to about 25% of the estimated incidence (Hald et al., 2019). Even with prevalence estimates hovering around 8–10%, the prevalence of sexual dysfunction in the general population is quite high, and higher still in the subset of people seeking help for diverse physical and mental health issues. Illnesses and their treatments (including surgeries, chemotherapy, and medication) may affect sexual performance and pleasure either directly (e.g., diabetic neuropathy resulting in ED, nerve damage following prostatectomy) or indirectly (altering body image after mastectomy). Many psychotropic medications have sexual side effects, most notably the selective serotonin reuptake inhibitors (SSRIs) frequently prescribed to treat depression and anxiety (mood states that may also interfere with sexual satisfaction). Sexual problems are also prevalent in individuals who have experienced trauma. Over half of the women and over one third of the men presenting for sex therapy report a history of sexual abuse (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014). However, there is a growing recognition that other traumatic experiences and complex trauma (more than one traumatic event) can also result in sexual problems (MacIntosh, 2019).

---

[2] A caveat is that sex therapy is not conducted in situations where there is domestic violence, a high degree of relationship discord, and/or severe substance abuse.

Cultural variations in the experience of problematic sexuality are inadequately addressed in Western sex research, primarily because the larger cultural context is not sufficiently considered. Most research in this area applies Western standards of sexuality to compare and document sexual difficulties in different cultural groups and to report on the experience of sexual dysfunction around the world. At present, therefore, the most that can be concluded is that people worldwide experience sexual problems, and that the manifestation of those problems and help-seeking behavior are at least partially determined by culture (Hall & Graham, 2012). Hall (2019) argues that the status of women is an important determinant of what defines problematic sexuality across cultures. While the expectation of sexual pleasure for men is universal, the same is not true for women. In many traditional or conservative cultures, female sexual desire and pleasure are viewed as dangerous, and their absence is not considered problematic. So, whereas low desire is one of the most frequent complaints that bring Western women to sex therapy, in other parts of the world, it is sexual pain (or other dysfunction that interferes with male sexual pleasure and/or with fertility) that bring women to therapy (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim).

In addition to sexual dysfunction, many (Western) couples report being unhappy with their sexual relationship. Couples are increasingly turning to sex therapy to improve their sexual connection even in the absence of a diagnosed sexual dysfunction. What Watter (2022) refers to as "relationship-deepening events" can often trigger a reaction that disrupts a couple's sexual connection. It is not unusual to find couples complaining of sexual problems after moving in together, getting married or engaged, coming out to loved ones (in the case of LGBTQ individuals) or having (or contemplating having) children.

Sexual satisfaction may be viewed as an important goal of sex therapy, but this is a tricky label. What is satisfying to some, is not so for others. Kleinplatz (2006, p. 345) argues, "Nothing kills desire more than doing what works—relentlessly," and she argues for the goal of optimal sexuality based on her work with "extraordinary lovers." In the same vein, many sex therapists hold workshops, write books, and/or continue to work with couples who have met their initial goals for therapy as they strive toward a sex life that is vibrant, dynamic, and "extraordinary."

THE PRACTICE OF SEX THERAPY

The Structure of the Therapy Process

The treatment of sexual problems is often interdisciplinary, involving more than one therapist and/or medical practitioners. It is not unusual for a couple to be referred for sex therapy by either another therapist (who may feel that addressing sexual problems is outside their area of expertise, or who may be working with one member of the couple) or a medical practitioner. Depending on the nature of the problem, the sex therapist may refer one or both members of the couple for medical evaluation or treatment. So, historically and concurrently, the couple may be discussing intimate details of their sex life on several occasions and to different professionals. Clearly delineating roles and boundaries (including limits of confidentiality) is important. Sex therapy is best considered as an interdisciplinary collaboration, and in our opinion, the couple's therapist is in an ideal position to coordinate the effort.

Take the case of Stella and Harold, a newly married couple in their early 20s. Stella was too fearful to have a routine Pap smear when she had her first appointment with a gynecologist. During that visit, Stella revealed that she and Harold, her husband of 18 months, had not been able to have intercourse. Stella was not only afraid of the pain she anticipated with intercourse, but she also worried that something might be physically wrong with her. The gynecologist examined her external genitalia, and while the physical examination revealed some areas of mild pain sensitivity, Stella's fear was not commensurate with her physical presentation. The gynecologist prescribed lidocaine cream and referred Stella and her husband to sex therapy.

Because of their shared prohibitive religious beliefs, Stella and Harold had not attempted to have intercourse prior to marriage and were very distraught when they encountered difficulties. Stella assumed that Harold, being a man, would know how to have sex. But Harold was as naive as she was, and was also disconnected from his sexuality, not quite knowing what aroused him and clearly not knowing how to arouse his wife. Early fumbling attempts had led to Harold trying to force his penis into Stella's vagina, which resulted in a lot of pain for Stella and shame for Harold. In therapy, Stella and Harold were able to examine some of the messages they received from their families, their church, and their community, so that they came to understand that the transition to having enjoyable sex was difficult for both of them. They worked in therapy on discovering and sharing their own sexual needs and pleasures. Homework exercises were designed in collaboration with the couple, such that Stella and Harold would first learn to enjoy sexual activities without attempts at penetration. The therapist referred Stella to a pelvic floor physical therapist, who helped release some of the muscular tension that was contributing to Stella's difficulty having intercourse. The physical therapist also gave Stella a set of vaginal dilators of increasing diameters to use at home. The sex therapist integrated the dilators into the couple's sex therapy homework. Stella learned to be more active and assertive sexually than she was culturally prepared to be. She also had to rebuild her trust in Harold, while Harold had to confront his own sense of sexual inadequacy. Over time, Harold became comfortable with Stella guiding him sexually, so they could have intercourse in a way that was not painful and was eventually pleasurable for them both. The reality of their sexual relationship evolved to be very different from what they had first imagined it would be. Their motivation to stay married and to have children kept them in therapy, which they attended every other week for 16 months.

As is evidenced in this case, sex therapists often find consultation with sexual medicine specialists, such as the gynecologist and the pelvic floor physical therapist, to be helpful in their work. Psychotropic medication to alleviate anxiety is not usually helpful when prescribed solely for sexual anxiety. Many of these medications have sexual side effects that interfere with not only sexual performance but also the goal of sex therapy to help people connect to their feelings of sexual pleasure. Nevertheless, it is a reality that many people who consult sex therapists have concurrent psychological or psychiatric issues that require medication. Consultation with psychiatrists is often needed when helping people adjust to the sexual side effects of needed medications.

While co-therapy teams are no longer widely or commonly used in sex therapy, it is not uncommon for sex therapists who work with couples to collaborate with the individual therapists of one or both members of the couple. Co-therapy teams were originally used in sex therapy based on the now defunct premise that men and women would be more comfortable discussing sexuality with someone of the same gender. As the client base for sex therapy has expanded to include individuals who are transgender, gender fluid (do not identify as either male or female), kinky, straight, gay, bisexual, fluid in sexual orientation, married, single, polyamorous, and even asexual, the notion of a male/female co-therapy team seems antiquated. What is required is that the therapist have some basic knowledge of human sexuality, an awareness of the rich diversity of sexual expression, and an empathic and nonjudgmental approach to treatment. Harold felt understood by the female therapist to whom he confided his sexual insecurity. Patients reveal themselves in psychotherapy as trust is built within the therapeutic relationship. The same is true for sex therapy. Harold would not have been able to reveal how inadequate he felt for not being able to have intercourse with his wife, for how guilty he felt for forcing himself on her, and how fearful he was that the marriage would not work, if he had not felt that the therapist was a person he could trust with these intimate details. Medical professionals were key in referring Stella and Harold for sex therapy and also for working on some of the contributing physical conditions (lidocaine for pain sensitivity, dilators, and pelvic floor physical therapy for muscle relaxation).

The collaborative approach that characterizes sex therapy extends to the use of resource materials. Books, videos, and websites are often part of the treatment process. As part of their homework, Harold and Stella were asked to read about sexuality in general and to share the reading of a sex book, highlighting passages that interested each of them and leaving the page marked for their partner to see. In this way, a discussion about sexual interests was facilitated in a couple that had little sex education, no prior sexual experience, and embarrassment that hindered their communication and connection. Homework assignments evolved as Stella and Harold became more comfortable arousing each other sexually and being sexually aroused in the presence of the other. Their subjective experience of sexual arousal inevitably led to the physiological responses (a firm erection and a lubricated and elastic vagina), that are necessary for painless penetrative sex. Instead of working directly on achieving erections or vaginal elasticity, therapy was directed at putting in place the conditions in which arousal would be experienced, both subjectively and physiologically. In the context of being aroused and with Stella guiding the process, dilators, fingers, and finally Harold's penis were inserted into her vagina, with mild discomfort occurring initially but then abating.

Therapy appointments are scheduled in accordance with the needs of the couple. There is often a need to allow enough time for the couple to experience their homework assignments or consult with a medical professional before meeting again with the therapist. Other times, therapy appointments may be scheduled weekly if the couple is experiencing high levels of distress either as a cause or as the result of the sexual difficulty. The interdisciplinary and collaborative nature of sex therapy is best accomplished when the different treatment modalities are concurrent rather than consecutive. Stella and Harold were seen approximately twice a month, which allowed them to do their reading assignments and engage in planned sexual activities with each other between sessions. The pacing of their sessions was also determined by the urgency they felt to reach their goal of having intercourse, so they could conceive and start their family. This motivation encouraged Stella to maintain twice-monthly couple therapy sessions even when she was meeting with the physical therapist two or three times a week.

Since it is a sexual problem or goal that brings couples to sex therapy, reaching that goal often means that therapy ends. As with other therapies focused on the alleviation of observable symptoms, therefore, sex therapy is typically of shorter duration than therapies focused on more chronic issues. However, in our experience, it is not unusual for couples or individuals to stay in therapy even when their sexual symptoms have improved. They either find ongoing therapy beneficial or they have other issues they may now choose to address. A time-limited approach is most often reserved for therapy when the goal is improving or enhancing sexual pleasure, performance, and/or connection when the baseline is a good relationship with at least minimum "functioning" sexuality. Weekend workshops, couples' retreats, or time-limited groups focus on enriching functional sexuality. Couples who face medical conditions that can affect sexuality (e.g., prostate, breast, or cervical cancer survivors) may also participate in time-limited therapy. Programs for prostate cancer survivors to help preserve their preoperative erectile functioning and groups for women with vulvar pain are just two examples of such groups.

The Role of the Therapist

In the early days of sex therapy, the role of the sex therapist was defined by the PLISSIT model, a model that is still relevant today (Annon, 1976). The acronym stands for Permission, Limited Information, Specific Suggestions, and Intensive Therapy. According to Annon (1976), many people with sexual difficulties require permission to have and enjoy their sexual thoughts, feelings, and behaviors. Straight men who enjoy watching gay porn, couples who are interested in experimenting with opening their marriages to other sexual partners, and men and women wanting to enjoy anal sex play may be some examples where giving "permission" is helpful. Most often, "permission" (better defined as having a nonjudgmental stance) is best accompanied by limited information, a process now referred to as "psychoeducation."

The following vignette demonstrates the process of psychoeducation in the course of ongoing therapy. Maya and Crystal were in therapy to deal with the aftermath of Maya's affair with a coworker, which ended upon Crystal's discovery of the affair. They wanted help to rebuild their sexual relationship. However, in an individual session, Maya confided that she was sexually bored, which she thought was a reason for her infidelity. She had wanted to introduce some bondage and impact play (spanking) into her sexual activities with Crystal even before her affair, but she believed that Crystal would not be interested. Now she worried that her requests would reignite Crystal's relentless questioning regarding the affair (Did she do that with the other woman? How often? Where? When? And always the question, Why?). The therapist helped Maya be patient in making sexual requests of Crystal and in understanding that the urgency she was experiencing was related to anxiety about being trapped in a marriage in which her emotional needs were not met. The only child of highly successful, political, and preoccupied parents, Maya knew what emotional neglect felt like. Over time, Maya was able to tell Crystal about her interest in kink. The therapist gave permission (normalized) the interest in bondage and impact play (no, it was not a way to act out anger) and provided information and specific suggestions in the form of books to read and some guidance on how to negotiate safety and boundaries should they decide to try some of these activities. The therapist, aware that Crystal was anxiously attached to Maya, encouraged her to be curious about Maya's interests but remain noncommittal about engaging in them, so that Crystal could consider Maya's requests as requests and not as demands or prerequisites for staying in the marriage.

It is important for the therapist not to impose their own ideas or standards of sexuality onto the couple but rather to provide the safety of the therapeutic relationship such that the couple can explore, experiment, and develop their unique sexual relationship. The information and specific suggestions provided by a sex therapist should not come in the form of directives or the nonjudicious use of self-disclosures: "I use this type of vibrator, I'm sure you will enjoy it too" or "My favorite erotic movie is___. I'm positive that you will get turned on by watching it." Disclosure on the part of the therapist sometimes means disclosing ignorance, and such disclosures may model curiosity, interest, and acceptance. It should be noted that all therapist self-disclosures should be with the best interests of the patient in mind, and the development of an authentic, genuine therapeutic relationship. Therapists who are part of a sexual minority may disclose this to couples who are also part of the same community (see also Chapter 23 on queer couples, in this volume, by Coolhart). LGBTQ, kinky and trans therapists are often out to their clients, as this allows them to be more authentic as therapists and also because they may be likely to run into one another in their small communities.

A sex therapist is not a sexual aficionado, or even a sex expert. It is impossible for any one person to have expertise in all the rich variation of human sexual experiences. Sex therapists are psychotherapists who are interested in helping individuals and couples understand, express, and enjoy their sexuality. By training and experience, they have come to appreciate how sexuality is an integral part of a person's core identity and the foundation of a couple's relationship.

The therapist who confronts sexual issues in treatment must be prepared to weave a tapestry incorporating all layers of the PLISSIT model as required by the couple. Sexual disconnection that defies cognitive-behavioral strategies requires intensive therapy. Hall and Graham (2020) argue that culturally sensitive sex therapy, which requires that therapists understand the meaning behind sexual complaints, is simply good therapy. David Scharff has opined that sexual complaints are in reality psychosomatic disorders, and Daniel Watter, in discussing male sexuality, has stated more bluntly: The penis speaks (Scharff & Scharff, 2011; Watter, 2022). Difficulty reaching orgasm for men and women, ED, PE, and sexual pain, along with a lack of desire for one's partner, often bespeak trauma, fear, psychic pain, and loneliness. Watter (2018) takes an existential perspective and suggests that death anxiety may be at the root of disinhibited or out-of-control sexual behavior (often referred to as "sex addiction").

Assessment and Treatment Planning

When couples present for treatment regarding sexual problems, there are typically four sessions that are considered as assessment. We recognize, of course, the artificial and arbitrary nature of this distinction, as people continue to reveal themselves as therapy progresses and therapeutic work begins, not after the assessment but at the moment of first contact. In the four-session model, the couple is initially seen together to allow the therapist to get an understanding of the sexual problems they are experiencing from their vantage point. This avoids allegiances being formed with any one person or preconceived ideas taking shape prior to meeting the two members of the couple. The couple is asked to talk about the evolution of the sexual difficulty in the context of their relationship, or to elucidate their goals for a stronger sexual connection in the absence of any defined difficulty. The therapist is able to see how the couple functions together, how each person relates to the other, if blame is assigned, or empathy extended.

In the second and third sessions of this model, each member of the couple is seen individually to get an idea of what each may be bringing to the problem and what each may contribute to the solution. Individual histories are taken, focusing on experiences of sexuality and how these experiences may impact their current sexual relationship. We often begin individual sessions with the inquiry; "What do *you* think is the reason for this problem?" In the individual sessions, the invitation is extended to talk about issues and perspectives that may best be discussed without the partner present. For example, Maya talked bluntly about feeling bored by sex with Crystal, Andrew disclosed his debt, and Harold worried about his own sexual incompetence, something he wanted to hide from Stella. These disclosures may have come later in the therapy process but were helpful to know up front. Therapists need to be clear to members of the couple, beforehand, as to whether their individual sessions are confidential, and if so, how the therapist will handle sensitive disclosures as part of the ongoing therapy (e.g., past or ongoing infidelity, trauma history, sexual attraction to others; see also Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen). We believe that it is better to know who and what we are working with and so promise confidentiality, with the proviso that we may encourage individuals to share insights and information in couples' sessions. Some sex therapists argue that as the couple is the client, there can be no confidentiality for the individuals involved. Again, this issue is left to the discretion of the sex therapist working with a particular couple. Sometimes therapists may find it helpful to have more than one individual session with members of the couple (Iasenza, 2020; Watter, 2022). The importance of individual psychological factors, as outlined in the biopsychosocial model, may indeed require more (or less) time with each member of the couple, a determination that is best left to the therapist.

The therapist working with Stella and Harold followed the four-session assessment model. They were highly motivated as a couple to work on consummating their marriage, and the therapist wanted to avoid stigmatizing Stella as the sexually dysfunctional member of the couple. One of the first pitfalls to avoid is identifying one person as "dysfunctional" and the other as healthy. The person who is not manifesting the problem (e.g., Harold) may try to align with the therapist to "help" his partner. An initial therapeutic task, best addressed immediately in the assessment phase, is to shift the perspective from "his or her problem" to "our problem." Additionally, when dealing with a couple, any problem that manifests itself in one partner will affect the other (e.g., sexual pain in one partner will likely affect the other's desire and/or arousal). Sometimes the sexual problem is related to issues in the relationship, but even when this is not the case, the therapist must always consider the impact of sexual difficulties from the perspective of both members of the couple. A shift happened for Harold in his individual session when he began to see the problem as their joint fear of intercourse.

In sex therapy, but especially in the early stages of assessment, the therapist asks direct questions about sex in order to understand the nature of the sexual discontent. These questions often help the couple reflect on sexual decisions they take for granted. Recall the case of Monica and Andrew, who struggled with PE, and consider the following exchange between the therapist and the couple:

THERAPIST: (*to Andrew*) When you are having sex, how do you decide it's time to have intercourse?

ANDREW: When I realize I am going to cum. I know I have to hurry or else it will be too late.

THERAPIST: Too late for what?

ANDREW: To have sex, of course!

THERAPIST: Oh, aren't you already having sex?

ANDREW: Okay, okay, yes, we're having sex, but intercourse, real sex. That's what Monica wants.

THERAPIST: So, once you start having intercourse, how long is it before you cum?

ANDREW: I don't know, I don't time it.

THERAPIST: Of course, but what's your best guess?

ANDREW: Like, about a minute, maybe two.

THERAPIST: And what have you tried to help you last longer?

ANDREW: I've tried everything! I dig my nails into the palms of my hands, hoping the pain will distract me. I've tried thinking about work, about baseball, I've counted backwards by 7's.

THERAPIST: You've tried a lot of ways to distract yourself from feeling sexual pleasure.

ANDREW: Oh yeah, I've tried wearing not one, but two condoms, and I've used those numbing creams I've bought online. What a waste of money!

THERAPIST: Well, you've tried a lot of things to last longer during intercourse. And you said that you're doing this not for your own pleasure, but because this is what Monica wants. (*turns to Monica*) So, Monica, is Andrew right?

MONICA: No! I do want to have sex, but not like this. (*looking at Andrew*) As soon as you get hard, you just get straight to it. Don't tell me you care about me—you just care about getting off. And it's not 2 minutes, more like 30 seconds!

ANDREW: It's no fun for me, let me tell you that! I'm trying my best, goddamnit!

THERAPIST: So, if neither of you are enjoying this routine, why do you keep doing it?

In addition to knowing that Andrew indeed ejaculates quickly and that he has tried and failed to control this, this brief exchange also reveals the difficulty this couple has with communication and the anger and animosity each feels. In this initial session, the therapist observed and encouraged dialogue between the partners in order to better understand their relationship and their style of communication.

There are a multitude of questionnaires designed to diagnose sexual dysfunctions and difficulties, but these are primarily used in research contexts. And although some therapists devise their own questionnaires, we believe that the clinical interview is the best practice, as it also allows the therapist to assess ease or discomfort when discussing sex, to view the couple's interaction as they agree or disagree on key matters, and to truly understand the individuals' and couple's experience of their sexuality.[3] Furthermore, some people are put off by the use of questionnaires, and this may be true for certain ethnic groups, sexual minorities, and others who may be distrustful of systems that rely on too much paperwork (Kelly & Shelton, 2013). While an overreliance on checklists or questionnaires is not advisable, clinicians can refer back to the biopsychosocial model to guide their assessment. Key areas of assessment, according to this model are listed in Table 19.1. One important factor to highlight is the need to determine whether and to what degree the couple's sexuality is impacted by biological factors. Assessing the circumstances in which the sexual dysfunction manifests can give some indication of organicity. A problem that arises only in some contexts (e.g., erectile dysfunction during partnered sex, but not during masturbation) may be less likely to have a physiologic root cause than one which occurs in all contexts (alone, partnered, different partners). Where there is any question, a referral to a sexual medicine specialist, a urologist, or gynecologist is good practice.

During the fourth session (or whenever members of the couple are brought back together), the therapist outlines a rudimentary understanding of the couple's difficulty and proposes a treatment plan, setting the stage for the collaborative process of therapy. The objective of the assessment phase of therapy is not to gather all the information that one will need in order to work with the couple, but to get enough information to know how to proceed and when not to. Moreover, sex therapy cannot be done in the context of relationships in which one partner (often women, in traditional or conservative cultures) does not have the right to make choices about their own sexuality and their bodies (Hall, 2019). Sex therapy is predicated upon the premise that both partners have a right to consent, or not, to sex, to certain sex acts, and to control the outcome of those acts (e.g., a right to control one's fertility, to not be shamed or ostracized, or, more extremely, to suffer banishment or death, which in some cultures is the consequence of what are considered sexual transgressions). Barring these extremes, the purpose of assessment is to get a sense of direction as the couple's story unfolds.

Goal Setting

Couples are asked about their goals for sex therapy at the outset of treatment, but goals evolve. For example, Andrew and Monica initially came to therapy with the goal of "fixing" Andrew, so that he could last longer during intercourse. But Andrew had already tried to "fix" the problem on his own, which had worsened their already strained marital dynamic. Reframing the problem from Andrew's sexual ineptitude to a couple's problem necessarily refined the goal of therapy. Monica came to understand that her anger over never having her needs met in her family of origin led her to appear to be selfish, demanding, and passive in relationships. Her mantra might well have been "Whatever you give will not be enough." This matched perfectly, if sadly, with Andrew's belief that he could never be good enough. Even in the initial session, the therapist challenged their goal asking why they continued to engage in sexual behavior (to pursue a goal) that was not satisfying for either of them. With encouragement from the therapist, Andrew and Monica refocused on enhancing their sexual pleasure and intimacy, a goal that required them to improve their marital relationship alongside the sexual one. In essence, regardless of the presenting problem, the goal of sex therapy involves restoring or experiencing sexual pleasure. Couples may believe that resolving a sexual symptom may result in sexual pleasure, and oftentimes it does. However, sometimes the sexual symptom is the outward manifestation of a deeper problem.

For example, consider Xavier and Darius, a cisgender, gay couple in their late 20s. They have an open relationship in which they have agreed to a "don't ask, don't tell" policy regarding sexual encounters with others. However, they came to therapy with Darius's complaint that Xavier never wanted to have sex with him. Xavier agreed that he had little or no desire for

---

[3] One exception is when the novice sex therapist is uncomfortable having discussions regarding sex. In such an instance, a more structured sex history questionnaire may be helpful in assisting the therapist not to stammer or stumble over the questions.

TABLE 19.1. Assessment Areas According to the Biopsychosocial Model

Biological

Purpose: to determine the extent to which physical causes are influencing the sexual difficulty

Assess: Overall physical health taking age into consideration; risk factors such as ongoing/past disease states (e.g., diabetes, cancer), treatments for current or past physical ailments (hypertension medications, psychotropic medication), injuries or history of, lifestyle factors such as smoking, alcohol and drug use.

Assess: The symptom presentation

Onset of the symptom: gradual versus abrupt

Duration of the symptom: lifelong or acquired

Manifestation of the symptom: in all situations (e.g., solo and partnered sex) or situational (only with some partners and/or on some occasions)

Action: Refer to sexual medicine specialist or another medical practitioner as needed.

Psychological/interpersonal

Purpose: to determine the contribution of individual factors and relationship dynamics

Assess: Sexual history, relationship history, trauma, psychopathology, attachment style, ongoing/past infidelity, commitment to the relationship, domestic violence, substance abuse

Assess: Symptom presentation as above

Action: Refer for individual therapy in case of significant trauma, psychopathology, substance abuse, lack of commitment to the relationship. Refer out or treat severe relationship dysfunction first, address domestic violence if you have the expertise, or address it by referral or refusal to treat the couple until the issue is resolved and safety is assured.

Sexual/relational

Purpose: to determine the level of sexual knowledge, skill and experience

Assess: Particulars of the sexual interactions: who initiates sex and how, determine if enough stimulation is occurring to produce a physiological response (e.g., erection, orgasm), ask about what sexual activities occur.

Action: Refer to psychoeducation, self-help books, instructional videos.

Social/cultural

Purpose: to determine the contribution of societal and cultural messages regarding sexuality

Assess: Messages from family, friends, religious organizations, schools, as well as inquiring about cultural values and beliefs, societal laws and restrictions, if the individual was born or raised in a different culture/country or is a first-generation offspring. Apply similar assessment inquiry to people who identify as part of a sexual minority (e.g., LGBTQ, kink).

Action: Check your biases, get supervision as necessary, integrate understanding of cultural constraints and strengths into treatment planning.

sex with Darius (or anyone else), but he attributed this to long hours at work and also doing all the housework. Darius's goal for therapy was for Xavier to get his sexual desire back. He assumed that after he detailed his sexual complaints, he would no longer need to be part of the therapy. Xavier's goal, like many people with low or no desire, was to *want* to desire to have sex. He also assumed that, as the identified patient, he would be in therapy alone. In the meantime, he hoped that Darius's sexual needs would be satisfied by others. However, as therapy progressed, Xavier came to understand that his history of being shamed and bullied for being Black, gay, effeminate, and artistic in a community that valued none of those attributes had led to a deep self-hatred. Darius, who had had the opposite experience, in which his Blackness, his attractiveness, and his masculinity were prized, realized that he had equated admiration and intimacy. Darius didn't just want to be wanted; he relied on being (sexually) wanted for his sense of himself, and for some semblance of connection. He was unable to empathize or read cues from Xavier, and as therapy progressed, he was able to identify a deep feeling of loneliness. The problem was complicated and clarified by the fact that in addition to having little or no sex with Xavier, he was having sex with others in a way that further alienated him from Xavier (e.g., crossing boundaries by having sex with Xavier's coworkers, inviting people to their home for sex, repeatedly cajoling Xavier to engage in a threesome despite his abject terror of such a situation). Ultimately, Xavier and Darius decided they each wanted individual therapy, in addition to their work in sex therapy. They understood that their goal for therapy, to have a pleasurable sexual relationship with each other, would be accomplished only when they made progress on their individual issues.

This case highlights the evolution of goals as therapy uncovers the factors responsible for problematic or unsatisfying sex. What originally appeared to be a straightforward case of Xavier's low desire turned out to be more complex, involving issues of self-worth, boundaries, and intimacy. The earlier case vignettes illustrated that the goal of sex therapy, to improve the experience of sexual pleasure, is often accomplished by improving sexual performance (e.g., learning to experience or delay orgasm, to maintain an erection, to have pain-free intercourse). Other times, sexual pleasure is improved when the couple adjusts to changes in sexual functioning that may be a part of the aging process, an underlying physical condition, or a consequence of medical treatments. And then there are cases, such as Xavier and Darius's, in which the goal of improving sexual pleasure involves healing from trauma, attachment injury, or other psychic challenges.

People often present to sex therapy as a last resort ("If this doesn't work, then it's divorce"). Sometimes they hope sex therapy will help them out of a dilemma inspired by infidelity ("Maybe if sex is better with my spouse, I won't want to cheat . . . "). Infidelity, past or ongoing, and/or the prospect of divorce do not necessarily preclude sex therapy, although they do require skill and patience on the part of the therapist. It is important to recognize the futility of the goal of keeping a couple together when the process of therapy may expose deep fissures from which people cannot or choose not to heal. Ongoing infidelity that is a secret presents one of the most daunting challenges for a sex therapist (see also Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder). Is it helpful to work with a couple to improve their sexual relationship when one person has a secret sexual relationship (or secret sexual outlets, e.g., multiple sex partners, sexting, hiring sex workers, engaging in online sexual activity)? Couple-based sex therapy may be possible if the transgressing partner truly wants to work to be more authentic, present, and committed to their spouse and is engaged in therapy to work on their issues. More individual sessions interspersed with couple's sessions will likely be necessary in these cases. Discomfort on the part of the therapist needs to be factored in, and a referral for individual therapy and cessation of couple sessions is not wrong in these situations either. Ongoing substance abuse may be treated in a similar fashion, but domestic violence precludes working on the sexual relationship (also see Chapter 25 on alcohol problems by McCrady, Epstein, & Holzhauer, and Chapter 17 on partner aggression by Epstein, LaTaillade, & Werlinich, both in this volume). As stated earlier, sex therapy is predicated on equality and safety, and if these two preconditions cannot be met, therapy focused on a sexual complaint cannot occur.

Process and Technical Aspects of Therapy

Sex is integral to both the goal and process of sex therapy. As originally conceived by Masters and Johnson, sexual exercises were designed to help couples alleviate performance anxiety to improve their sexual function. Sex therapists followed established protocols, with sensate focus being the mainstay of homework exercises. As sex therapy has evolved, so, too, has the application of sexual exercises. While some still advocate that sensate focus be applied in the manner intended by Masters and Johnson (Weiner & Avery Clark, 2014), others tailor sensate focus and other sex therapy exercises to the specific needs of the couple. We belong to this latter group and also recognize that directive sex therapy exercises are not essential to every sex therapy case. Sex therapy was originally developed before the Internet provided sexual information and experiences, and before the proliferation of sexual self-help books and sex manuals. Couples are no longer solely reliant on sex therapists for ideas as to how to change their sexual repertoires. They may consult with sex therapists for guidance on how to choose or tailor new practices in a relationally sensitive manner. Sex therapists can also help their patients navigate the often-confusing array of sexual information and misinformation that proliferate on the Internet and in bookstores and magazine racks.

Sensate focus, a series of exercises originally designed by Masters and Johnson, progresses from nongenital to genital touching and culminates in intercourse. The original intent of these exercises was to allow people to focus on their physical experience without judgment or "spectatoring," so named by Masters and Johnson to describe a process by which people step outside of their experience to evaluate their sexual performance. According to Masters and Johnson, when sexual participants view themselves from an outside perspective, this increases performance anxiety and interferes with sexual function. Sensate focus exercises involve nondemand touching (no effort to arouse another, no obligation to feel aroused), while encouraging individuals to focus on their sensual experience. The application of mindfulness meditation techniques to sex therapy (Brotto, 2018) may be seen as an updated variation of encouraging people to focus on their sensual experience without engaging in judgment.

The therapist working with Stella and Harold used sensate focus exercises to help the couple learn about their bodies and their experience of sensual and sexual pleasure. They also learned to communicate their pleasure to each other during the exercises, so that Harold learned how to arouse Stella in a manner that was also arousing for him, and vice versa. These exercises worked well for the couple. Previously, Stella was distracted from pleasure by anxiety about pain with attempts at intercourse. Harold was similarly distracted by his fear of causing Stella pain, and by his concern that Stella's arousal would interfere with his love for her as a pure Christian woman. The boundaries or rules that were applied to the exercises helped the couple not to worry about intercourse (attempts at penetration were not allowed until much later in the process) and the graduated approach helped Harold not to be overwhelmed with sexual feelings that were at odds with his ideal of Christian love. When they began exploring genital touch, both Harold and Stella were delighted to experience arousal and pleasure, and eventually both had orgasms from the other's touch. The dilators that Stella was using in her physical therapy were incorporated into the sensate focus exercises, so that once Stella was aroused, Harold would insert a small vaginal dilator while continuing to pleasure Stella with breast and/or clitoral stimulation. Harold was eventually encouraged to insert his fingers, a pleasurable activity for the two of them, but using his fingers also allowed Harold to experience the elasticity of Stella's vagina, so that he was less fearful of hurting her when he attempted intercourse.

A variation of sensate focus was used with Monica and Andrew, once therapy had addressed and ameliorated much of the anger and animosity. Their graduated exercises progressed more quickly to genital touching, incorporating elements of the start–stop technique (described later) to help Andrew control the timing of his ejaculation with increasing levels of sexual stimulation (for him and for Monica).

Sensate focus was not an appropriate intervention for Crystal and Maya. Recall that Maya found her sexual relationship with Crystal "boring." Sensate focus would have risked alienating Maya further, and the goal of improving communication and increasing pleasure could be accomplished without it. Maya had asked Crystal to consider incorporating some elements of kink into their sexual repertoire. Ultimately, Crystal told Maya that she was not interested in impact play the way Maya imagined it ("It's just not me"). Addressing Maya's disappointment, the therapist asked, "Maya, if I'm correct, you want to feel more intensity, in a sensual way during sex—is that right?" When Maya agreed, the therapist then suggested that together Maya and Crystal think of ways that might be accomplished. Crystal was excited about the prospect of improving their sexual intimacy after the hurt of Maya's affair. The therapist prompted them to talk about what they found erotic in the mainstream films they watched, read sex books, and imagine sexual scenarios and share fantasies with each other as they experimented and explored sensuality. Maya and Crystal played with ice cubes on their nipples to intensify sensations, feather dusters to tease, and sex toys to add some fun, all experiences they came up with themselves. There was no direction from the therapist other than encouragement to explore, to be curious, to be open and to communicate with each other.

Other techniques used in sex therapy include masturbation retraining (focusing on pleasurable sensations while self-stimulating in order to increase arousal and experience orgasm), and the stop–start technique, which is used to help men focus on their sexual arousal so that they can control the timing of ejaculation. Andrew had tried to control his ejaculation by distracting himself from his arousal in the hope that diminishing his sexual pleasure would delay orgasm. Instead, Andrew was instructed to focus on his arousal so that he could identify the point of ejaculatory inevitability (a physiological marker when the process of ejaculation is underway) and then to be able to identify when he felt close to this point. By paying careful attention to his physical arousal, Andrew could moderate the stimulation he received, so that he could stay aroused until he wanted to ejaculate.[4] Andrew was able to delay his ejaculation on his own

---

[4] A variant of the stop–start technique is colloquially referred to as "edging." This refers to the process by which men play with arousal up to the edge of ejaculating, only to pull back. Edging is said to enhance the experience of orgasm, not just to delay the timing of it.

(masturbation) and eventually with some partnered stimulation. However, he continued to have difficulty delaying his ejaculation during intercourse, the activity that caused him the most anxiety because he believed, not incorrectly, that it was the standard by which Monica judged him. When Andrew could successfully delay ejaculation during most sexual activities with the exception of intercourse, the level of conflict within the couple escalated. It was important to stop prescribing exercises and address the conflict on an intrapsychic level (Monica's sense of deprivation and Andrew's low self-worth), as well as a relational level (Monica found a man who often triggered the feelings of deprivation, but who nonetheless tried, while Andrew found a partner who would trigger his feelings of inferiority, but who nonetheless was committed to him). A recognition of this dynamic added depth to the sex therapy homework. Sensate focus exercises were offered to Monica as an opportunity to teach Andrew about what she needed rather than to assume that he was depriving her. Including stimulation of Monica into Andrew's stop–start protocol allowed him to experience and overcome his anxiety as he learned to attend to Monica's needs, while also being able to tune into his own sexual excitement, so that he could learn to delay his ejaculation in several situations before ultimately being able to do this while having intercourse.

It is the couple who should determine the nature of their sexual relationship without pressure to conform to the therapist's or anyone else's idea of what a good sexual relationship should be. In order to help couples with sexual pleasure and connection, a therapist needs to be aware of their biases, so that they do not influence the trajectory of therapy. As people age, they may need help navigating sexuality with bodies that no longer conform to cultural ideals of sex, which are often based on young, healthy, able-bodied men and women. When intercourse is painful due to vaginal atrophy associated with menopause, or when erections become less reliable, or men find ejaculation does not easily occur with each sexual encounter, couples may need encouragement to be creative about their sexuality while accepting the reality of aging. People with differing abilities physically, cognitively, and/or emotionally, as well as sexual minority and transgender individuals and people from religious or cultural backgrounds that differ significantly from those familiar to the therapist, may challenge therapists' notions of "healthy" sexuality. Sex therapists do not decide what constitutes good sex for their patients, but they do know how to help their patients find the answer.

Sex therapy typically ends when the couple has achieved their goal of more satisfying sex. We have stated many times that sex therapy is a collaborative process, and so it is with termination. Typically, as couples are reaching their goals, the prospect of termination arises as therapy appointments are spaced with increasing intervals of time between them. In discussing the end of therapy, couples are cautioned that sex can and will be disappointing at some points in time, and they are encouraged to consider the bigger picture, and that in the context of a satisfying sexual and emotional relationship, occasional dysfunction or sexual disappointment is inevitable and can be tolerated, forgiven, and accepted. The couple is reminded that they have tools now (the techniques used in the sex therapy homework) should problems arise in the future. Often, couples are scheduled for a follow-up visit months after regularly scheduled appointments cease, or they are encouraged to reach out should they require a "tune up."

The sex-positive approach of sex therapy should not be translated by sex therapists into an advocacy for sex. The therapist should not be the most motivated or enthusiastic proponent for sex of the three people in the therapy room. If a therapist pushes too hard or advocates for what they believe is sexually healthy or desirable for a patient, the risk of alienating or psychologically harming the patient is great. An awareness that people make life choices based on a consideration of other factors, independent of sexual fulfillment, needs to be met with respect. Some people may choose to stay with a partner to whom they are not attracted, to live in a body with which they are uncomfortable, to have sex they do not find fulfilling, or to forego sex altogether because their faith, their family, their community, or their mental health is a more important priority. Neither is sex therapy a panacea. Although Monica and Andrew had some degree of success improving their sexual and marital relationship, Andrew contacted the therapist several years later to request individual therapy following their divorce. In the intervening years, Andrew lost his high-paying job, and his prolonged unemployment was more than the relationship could bear. Andrew became depressed and, according to him, Monica felt a renewed sense of deprivation and anger. Their sex life dwindled to nothing as the fighting escalated until they decided to divorce, a decision Andrew acknowledged was made easier by the work they had previously done in sex therapy.

Mechanisms of Change

In sex therapy, couples are challenged to view their individual and joint sexuality in a new light. They are challenged to question cherished beliefs such as "intercourse is real sex," "losing sexual desire means you have fallen out of love," and especially the belief that sex should be "natural." Couples may come to see that their sexual relationship is a reflection of their interpersonal dynamic, as it was for Andrew and Monica, or they may become more aware that their sexual preferences are a manifestation of their cultural and spiritual beliefs, as it was for Stella and Harold. Couples like Xavier and Darius can also be confronted with the fact that their sexuality is a culmination of their individual historical experiences that have also impacted their sense of safety, self-esteem, and (dis)comfort with intimacy. Sex therapy can also provide a concrete direction for improving or deepening a commitment or connection, as it was for Maya and Crystal. Since sex therapy addresses problematic sex *and* promotes sexual growth using insight, psychoeducation, experiential exercises, and relationship interventions (borrowing practices from emotionally focused therapy [Johnson, 2017; also see Chapter 6, in this volume, by Johnson, Wiebe, & Allan], cognitive-behavioral therapy [see Chapter 3, in this volume, by Baucom et al.], and the Gottman method [see Chapter 16, in this volume, by Gottman & Gottman; Gottman & Gottman, 2015], among others), the question arises as to what it is about this rather motley assortment that works.

One of the great benefits of sex therapy is that it provides a nonjudgmental space for couples to talk about one of the most intimate and also potentially most shameful aspects of their life. The psychological benefits of sharing details of sexual experiences with a curious, compassionate, helpful, and accepting therapist cannot be overstated. The relief when a couple shares their sexual distress and is met with compassion and understanding is palpable. But a sex therapist, to be successful, must also be creative in being able to encourage patients to experience in "real life" the changes they are making in therapy, or to use patients' sexual experiences to promote insight, understanding, and change in therapy. Andrew had to confront his shame regarding never being good enough, both in the therapy room and in the bedroom. Harold and Stella experienced their fear of intercourse in their sexual interactions, as well as their discussions in therapy. This combination of experiences, in real-life sexual situations and in the therapy room, is the secret sauce that makes sex therapy work. Rather than avoid shame and fear, patients are helped to confront and overcome their inhibitions in a gradual or graduated manner. While some of the sex therapy techniques, such as sensate focus, have years of use and therefore a patina that radiates confidence and expertise on the part of the therapist employing these tools, we know from experience that it is the ability of the therapist to be finely attuned to the needs of the couple that makes sex therapy work. Along the way, patients necessarily acquire new skills. Andrew learned to control the timing of his orgasm, Stella and Howard learned how to arouse each other, to have intercourse, and to communicate their sexual preferences to each other. Maya and Crystal learned not only new skills but also to be creative lovers as they had the experience, supported by the therapist, of trying new things, not all of which were successful (i.e., not all of which were mutually enjoyed). But Maya and Crystal learned through experience that being disappointed sexually sometimes occurs, as it does in other aspects of life and relationships.

When working with couples, change does not always happen for both individuals simultaneously. Although one of the first therapeutic tasks is to reframe the sexual problem as a problem the couple is experiencing, it frequently occurs that one person is identified as the dysfunctional one. Andrew was the identified patient in his relationship, with Monica resisting therapeutic overtures. Resistance is often encountered when there is a power dynamic at play and there is an advantage to being the superior, or sexually functioning, person in the relationship. This was clearly the case, as Monica used Andrew's PE to shame him further for not being man enough to take care of her. Resistance can also reflect fear of having to revisit trauma or encountering shame or other painful emotions, as it was with Xavier and Darius. Maya wanted to enlist the therapist's help in changing Crystal, so that she would not have to experience feeling neglected as in her childhood marked by parental negligence and abandonment. Maya was able to process her resistance in therapy and to join with Crystal in creating a new sexual relationship. Monica was not so motivated, and Andrew often found himself in therapy alone, with Monica begging out at the last minute due to a scheduling conflict or poor health. Andrew was more open to making changes, and he began doing stop–start exercises and gained confidence in his sexual abilities. Because a couple is a system, a change in one part of the system necessarily results in change to the other. Andrew's progress made Monica uneasy. She always counted on Andrew to try (but fail) to please her. The possibility that this dynamic might change without her participation motivated Monica to return to therapy. At first, she simply redoubled her efforts to show Andrew how pathetic he was by complaining that since he could not control his ejaculation during intercourse, his progress in other sexual situations was irrelevant. Monica was difficult to engage in therapy, and she was difficult to like. She came across as selfish, self-centered, angry and demanding. But couple therapy requires the therapist to work with both members of the couple. The therapist worked hard to stay empathic with Monica, until Monica trusted her enough to share the depth of her anger at being betrayed by Andrew, who, despite his likable demeanor, had lied to her about his finances and also his sexual functioning, professing at first that he had never before experienced PE, only for her to discover after their marriage that this had been a long-standing and chronic problem. With her experience and emotions validated, Monica was able to participate in therapy and to discuss with Andrew her sense of betrayal. As he agreed to work on being honest and authentic in all aspects of their relationship, the couple was able to engage in sensate focus and stop–start exercises.

Treatment Applicability and Empirical Support

The complexity of sex therapy poses a significant challenge to outcome research, making difficult the identification of effective interventions for the wide array of presenting problems sex therapy addresses. Nevertheless, a body of research attests to the efficacy of cognitive-behavioral interventions for clearly defined sexual dysfunctions, with much of the recent literature coming from countries other than the United States. Researchers in Canada, Europe, and the Middle East are finding successful outcomes for the treatment of sexual pain, ED, PE, and low sexual desire (Meana, Hall, & Binik, 2020). Treatment outcome research in the United States has been dominated by the pharmaceutical industry, which has funded a rather impressive number of studies investigating the impact of pharmacological agents on sexual functioning. The conclusion reached by those studies comparing medication and time-limited cognitive-behavioral sex therapy is that the combination of these two approaches achieves the best outcome (Althof, 2020). However, it is important to recognize that combination therapy is often expensive and/or not available. Sexual medicine is a growing specialty, but at present it appears limited to large urban centers with teaching hospitals and is not widely available in less populated or rural settings.

The ethical concern regarding treatment availability and access is an ongoing issue for sex therapy. However, during the COVID-19 pandemic, teletherapy and telemedicine set the stage for easier access to sex therapists and interdisciplinary teams (Carvalho & Pascoal, 2020; also see Chapter 30 on telehealth and digital couple interventions, in this volume, by Doss, Knopp, Wrape, & Morland). This, however, does not address the reality that for many people sex therapy, sexual medicine, and health care treatment in general are simply too expensive. The financial burden places such services out of reach for the underserved and disenfranchised. This concern has yet to be adequately addressed in countries such as the United States (Watter, 2012).

Even though sex therapy is an effective intervention for sexual dysfunctions, these are not the only problems for which people seek treatment. Indeed, sex therapy continues to enjoy a rather unprecedented popularity among treatment seekers. Sexual minority patients, people grappling with issues related to gender, orientation, and fidelity, along with those struggling with sexual function and/or lack of fulfillment, seek out sex therapists in order to consult with knowledgeable and compassionate therapists with whom they can talk openly about sex (Meana et al., 2020). Recently, we commented on what we believe to be the applicability of sex therapy approaches for men who have committed sex offenses (Watter & Hall, 2020). Cantor (2014) has cogently argued for sex therapists to extend treatment to pedophiles, so that they may get much needed help to live with, but not to act on, their sexual interest in children. Individuals and couples who are economically disadvantaged, cognitively limited, and/or those with severe mental illness have not received adequate attention from the sex therapy community, and perhaps not from the psychotherapeutic community at large. Sex therapy has popular appeal and practical applications for a wide array of presenting problems and people seeking help. We believe that sensitive therapists who can tailor their treatments to the needs of their patients will be successful with a diverse clientele.

In the future, we believe outcome studies should focus on measures of sexual satisfaction rather than function. Psychotherapy outcome research is moving to have as an endpoint measures of the extent to which patients report feeling changed after therapy (Sandell & Wilczek, 2016). Yet Zilbergeld (1983) has opined that most people who engage in psychotherapy of all types assert that the therapy was helpful for them, while also reporting that the problem that brought them into therapy has not resolved. How, then, could these people be pleased with their therapy outcomes? This question may be of particular interest in the realm of sex therapy, as in the case illustration.

CASE ILLUSTRATION

Susan and Ray presented for sex therapy after approximately 4 years of marriage. Susan was 36 years old, and Ray was 39. Both were in good health, took no medications, and had no history of substance abuse. Their presenting complaint was that shortly after marriage, Ray lost interest in having sex with Susan. At the time of intake, Susan and Ray had not had sex for more than 3 years, despite Susan's repeated attempts to sexually engage with Ray. Ray was at a loss as to why he was no longer sexually interested, especially since he and Susan had a very active sex life in the 7 years they dated before marriage. Susan could not understand why Ray had become so nonsexual and worried that he no longer loved her, no longer found her attractive, or was having an affair. Ray emphatically denied that any of her concerns were true and said he just "lost his desire." Nevertheless, Susan was feeling rejected, and her self-esteem was plummeting.

Susan and Ray had consulted with another sex therapist in the preceding year but found the therapy to be unhelpful. After a brief intake, the sex therapist recommended they begin with sensate focus exercises in an effort to bring Ray more in touch with his lost sexual feelings, but the exercises were never done. Ray felt they were "juvenile," and although he claimed he was willing to do them, there were always "reasons" why the exercises could not be done. After about 8 weeks, both Susan and Ray concluded that the therapy was not for them, and they terminated treatment. However, although she had become increasingly discouraged, Susan did not want to give up therapy entirely and began searching for another sex therapist who might have a different approach. They received a new referral to me (DNW) from Susan's OB/GYN.

When Susan and Ray appeared for our therapy, they gave a good history of their relationship, both sexual and nonsexual, as well as their assessment as to why the prior treatment was not effective for them. They were then seen for three individual sessions, which both seemed to eagerly desire. I explained to them during our introductory session that the content of the individual sessions would be kept private and confidential. If there was something that I thought should be shared, I would tell them that was my opinion, but whether they decided to share information would be their call. The only information that would not be confidential would be if either of them desired any additional individual sessions. If these were to occur, it would have to be discussed in advance of the session, and both would have to agree. (It is our clinical experience that couples most often understand the need for confidentiality in individual sessions and typically are eager to have the opportunity to discuss their thoughts and feelings without having to censor themselves for fear of upsetting their partner.) Following the third individual session, they would then again meet with me as a couple, receive some feedback from me, and therapy would proceed going forward in a couple format. Clearly, this approach has risks. The keeping of secrets can be highly problematic in couple therapy, resulting in collusion. However, not giving individuals an opportunity to reveal themselves in a safe space also has its risks. I told Susan and Ray what I tell all couples: that this is my approach and there are many fine couple therapists who would proceed differently (i.e., no confidentiality of information gleaned from individual sessions, or no individual sessions at all), and I would be happy to make a referral if my approach was uncomfortable for them. In more than 35 years of doing couple therapy, I can only recall one couple who opted for a referral to a different therapist due to this protocol.

In his individual sessions, Ray discussed his concerns, as well as relevant details about his past, including his family of origin, and Susan did likewise. Both reported a mutually active and satisfying sexual life in the years they dated. However, within months of marrying, Ray lost all interest in having sex with Susan. He revealed during an individual session that while he resisted having sex with Susan, he was far from sexually disinterested or inactive. Ray reported a rather robust masturbatory life that included enjoyable solo masturbation three to four times per week. He found this to be a very pleasurable experience and seemed to feel genuine remorse for the pain it was causing Susan, especially since he still found her very attractive and loved her deeply. Still, he was unable to bring himself to engage sexually with her. His ambivalence toward sex with Susan was then understood as the real reason for Ray's resistance to the sensate focus exercises. He resisted anything that would move him closer to reengaging with Susan sexually but consciously was unaware of what the obstacle(s) might be. Ray found himself truly perplexed. Ray believed that Susan was aware that he masturbated but acknowledged that she was unlikely to know with what frequency and pleasure.

In discussing his family of origin, Ray recalled loving his parents very much, but found his mother to be intrusive and overbearing, and his father, distant and critical. His parents had a strained relationship, and they fought often. Ray recalled becoming his mother's confidant and often felt like a substitute spouse. While he cared deeply about his mother's happiness, the burden of responsibility he felt was oppressive. He recalled the difficult decision to attend college out of state but said it was the most liberating experience of his life. Ray recalled feeling a freedom he had never before known, and he blossomed through his college years. It was about this time that Ray met Susan. He recalled falling in love quickly and he enjoyed the time they spent together immensely. Susan was a wonderful companion, and their sexual activity was free, fun, and frequent. Ray didn't believe he had ever been happier.

After approximately 7 years of joyful dating, Susan broached the topic of marriage. Ray recalled feeling somewhat uncomfortable but was unsure as to why. He quickly dismissed these thoughts since he loved Susan and the time they spent together. He agreed, and the couple was married 6 months later. Ray reported feeling a growing anxiety as the wedding approached and in the weeks that followed the ceremony. For reasons he was at a loss to explain, he rapidly found himself looking for excuses to not have sex and turning more frequently toward masturbation. This trend quickly escalated to the point that Ray now resisted all sexual contact with Susan, and this unexpected, uncharacteristic, and unexplainable change is what led the couple to seek out the assistance of a sex therapist.

As the individual sessions continued, it became apparent that Ray's resistance was the result of a triggered childhood trauma[5] he suffered in being a "parentified child." To Ray, marriage was a trap in which he would be suffocated, stifled, and smothered. His sexual shutdown toward Susan had nothing to do with Susan per se, but rather served to shield Ray from the oppressive burdens of commitment reminiscent of his childhood. For Ray, this insight was groundbreaking, as he now understood the reasons for his resistance to sex with Susan. He said he knew he didn't lose desire for her and the self-protective trauma reaction narrative resonated strongly with him.

Susan also had a difficult family of origin. She was an only child of alcoholic parents and grew up feeling lonely. While she did not become the caretaker for her parents, she longed for their love and attention. She tried to be a "good girl," never make trouble, and make life easier for her parents. However, their alcoholism precluded them from recognizing or nurturing young Susan, and Susan, as is the case with many young children, assumed that the problem was that she was not lovable enough. When she met Ray, Susan's entire world changed. Ray couldn't pay enough attention to her, especially sexually. For the first time in her life, Susan felt desired, loved, and noticed. She could not believe her good fortune in finding Ray but was perplexed as to why he never proposed marriage. It took her many years to work up the courage to ask him to marry her. Much to her relief (and a bit of surprise), Ray agreed right way, and they were soon married. Susan was ecstatic, but her fears of not being lovable enough resurfaced a few months after marriage as Ray began to demonstrate less and less sexual and romantic interest in her. Unsure as to what was happening, Susan tried all she could to be more appealing to Ray. She bought sexy lingerie; planned romantic evenings, dinners, and getaways; and began to exercise more, all in an effort to regain Ray's interest and attention. Unfortunately, none of these efforts proved fruitful. Indeed, it seemed to Susan that the more she pursued, the more Ray resisted her overtures. As her individual sessions progressed, it became clear that Susan's traumatic upbringing was being triggered in her current relationship with Ray. In essence, both were reenacting the relational dynamic from childhood, and in doing so they were "triggering" each other.

When we resumed our joint sessions, both Ray and Susan reported they had found their individual sessions to be extremely helpful and eye-opening. Both reported that during the past few weeks, they had come to see themselves and each other more compassionately, through the lens of “softer eyes.” We discussed what they had each discovered, and both found it reassuring to have explanations for the dynamic that resonated. Ray’s fears of suffocation and entrapment, coupled with Susan’s fears of being unloved, undesired, and unnoticed, gave them a deeper understanding of the pursuer–distancer dynamic that had evolved. It also reassured them that they hadn’t made a mistake in choosing each other for a life partner. Once they were able to understand why their relationship had changed after marriage, the path forward seemed much clearer, manageable, and positive. Without going into details, Ray told Susan that his physical needs were being met through masturbation, and to his surprise and relief, Susan told him that she also found masturbation to be a pleasurable sexual outlet, although she greatly missed being with him.

---

[5] We define "trauma" as experiences that overwhelm an individual's capacity to cope.

While they now understood what was at play, moving forward was still complex, and Ray and Susan needed guidance in how to proceed. They were willing to engage in sexual exercises designed to restore their sexual connection, but initiating any sexual activity was difficult. Susan felt emotionally bruised from being rejected sexually the last 3 years. She was reluctant to initiate any physical intimacy; hence, initiating sex so that Susan would feel better played into Ray’s sense of emotional obligation and suffocation, thus paralyzing him. So I suggested that they schedule times to be together sexually. The idea of scheduling sex is off-putting for some who believe that sex should be spontaneous, but many couples have found this to be a successful strategy (Kleinplatz & Menard, 2020). Times were agreed upon in the therapy office based on what was logistically possible (avoiding work and social obligations). Furthermore, the idea of suddenly having sex again felt daunting to them both after essentially 3 years of abstinence. I also suggested that they start gradually, by lying together either naked, or with as little in the way of undergarments as they felt comfortable. They should then hold each other and caress face, neck, arms, and so forth, but they should not attempt to arouse each other or get aroused. They should focus on the sensations they were each experiencing. Ray was encouraged to focus on the texture of Susan’s skin, to note how soft it felt and how that softness might vary from her face to her forearms and neck. He was also instructed to notice how he felt when he was being touched. To notice without judgment—not “what do I like/dislike?” but to pay attention to how his skin felt when Susan touched him with soft or light touch, with circular motions or long sweeping caresses. Susan was instructed to do likewise.

In the session following this instruction, I asked both to report on their experience.

THERAPIST: Susan, what was it like for you to do this exercise?

SUSAN: Good and bad. (*Laughs.*) I loved being able to touch Ray and, of course, to have him touch me again. That was great. But I kept thinking about whether I was doing it good enough and worrying about what Ray was thinking.

THERAPIST: Not surprising, right? But I wonder which one you ultimately chose to pay attention to, the pleasure or the anxiety?

SUSAN: It’s not a choice. I just worry. I can’t help it.

THERAPIST: Well, maybe it could be a choice. Maybe you could accept that the worry will be there but choose to focus on the pleasure you are feeling.

By encouraging Susan to be an active agent in her own sexual pleasure, I was not only helping her enjoy her sensuality/sexuality but also helping Ray to see Susan as she was and not as a helpless person in need of emotional rescue. Homework exercises were scheduled and crafted to leave Susan and Ray wanting more. So, whereas the frequency of their premarital sex was several times a week, homework was scheduled for once a week or less. And I continued to advise a slow pace, no intent to arouse, no intent to reach orgasm, no intercourse. The reason I focused on intent is that arousal can occur without the intent to produce it, and the prohibition of intercourse helps mixed-sex couples steer away from routine or routinized patterns of being sexual; when intercourse is not the goal, arousal and pleasure can simply be experienced. Here is an exchange in which Ray is questioning the pace:

RAY: I’m not really sure why we can’t have sex. I mean that’s what we came here for. I’ve been getting an erection these last few times and well, why shouldn’t we just do it?

THERAPIST: So, Ray, let me ask you. Do you feel like having intercourse, or does it just make sense to have intercourse?

RAY: (*sighing*) I guess it feels like the logical next step.

THERAPIST: Seems like you might be teetering on the edge of obligation again.

RAY: Right. Right. But . . .

THERAPIST: Susan, what about you? How do you feel about having intercourse?

SUSAN: (*laughing*) I'm loving what we are doing now, frankly. This is the part of sex I've always really liked. Foreplay. I'd like to maybe do more, maybe have an orgasm . . .

RAY: (*laughing also*) I'd like to cum, too.

THERAPIST: So why don't you play with this exercise a bit. Don't try to give each other orgasms. Remember, orgasms are what happens when you get highly aroused. So just keep playing with what is arousing.

The slow pace of the exercises also allows desire to build. We often tell couples that desire is the wish, the yearning for something you don't yet have. And that feeling of anticipation can be exquisitely pleasurable. So, we encourage couples to enjoy and extend this feeling, to build and enjoy desire. When satisfied, desire diminishes, and nothing kills desire as much as obligation. If you have to do something, wanting to do it becomes irrelevant, and the only recourse to be oneself is to stand in opposition: "I don't want to"; "I won't."

Susan and Ray found that guidance and structure helpful as they reconnected sexually. As time went on, they took more ownership of what they were planning and scheduling, eventually adding intercourse to the variety of sexual activities they enjoyed. Sex was not nearly as frequent as it was before marriage, still requiring a schedule, and Susan and Ray both continue to struggle with their anxieties but remain committed to the improvement of their relational dynamic.

CONCLUDING COMMENTS

The cases in this chapter illustrate the breadth and complexity of the issues that people bring to sex therapy. What unites Andrew, who ejaculates quickly, with Ray and Xavier, who do not desire the partners they love, with Maya, who wants to be kinky, or with Harold and Stella, who are fearful of sex? These men and women, and their partners, chose and were helped by a treatment approach that addressed their sexuality directly, that helped them understand the perplexing ways in which sex was just not working out but also helped them become more satisfied with their sexuality (either by accepting, changing, or continuing to work on their sexual issues).

We have stressed in this chapter the need for some degree of sexual knowledge, for experience and therefore comfort in raising sexual issues with patients, and for clinical acumen in integrating various couple therapy approaches to sexual functioning as needed. Clinicians interested in incorporating sex therapy into their work with couples are encouraged to pursue more detailed descriptions of specific interventions for various dysfunctions such as those contained in the core resources listed below. Knowledge about specific interventions for specific disorders, as well as about strategies for promoting sexual enhancement in nondisordered couples, is essential but not sufficient for competent practice of sex therapy. Such interventions are likely to have benefit only when integrated within the broader compassionate, nonjudgmental, and clinically sensitive therapeutic context advocated here.

SUGGESTIONS FOR FURTHER STUDY

American Association of Sexuality Educators, Counselors, and Therapists (AASECT): www.aasect.org.

Hall, K. S. K., & Binik, Y. M. (Eds.). (2020). *Principles and practice of sex therapy* (6th ed.). New York: Guilford Press.

Society for Sex Therapy and Research (SSTAR): https://sstarnet.org.

REFERENCES

Althof, S. E. (2020). Treatment of premature ejaculation: Psychotherapy, pharmacotherapy, and combined therapy. In K. S. K. Hall & Y. M. Binik (Eds.), *Principles and practice of sex therapy* (6th ed., pp. 134–155). New York: Guilford Press.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Annon, J. S. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of Sex Education and Therapy, 2,* 1–15.

Bancroft, J. (2008). *Human sexuality and its problems* (3rd ed.). Edinburgh, UK: Churchill Livingstone/Elsevier Health Sciences.

Berthelot, N., Godbout, N., Hébert, M., Goulet, M., & Bergeron, S. (2014). Prevalence and correlates of childhood sexual abuse in adults consulting for sexual problems. *Journal of Sex and Marital Therapy, 40,* 434–443.

Brotto, L.A. (2018). *Better sex through mindfulness.* Vancouver, Canada: Greystone.

Brotto, L. A., & Velten, J. (2020). Sexual interest/arousal disorder in women. In K. S. K. Hall & Y. M. Binik (Eds.), *Principles and practice of sex therapy* (6th ed., pp. 13–40). New York: Guilford Press.

Cantor, J. M. (2014). "Gold-star" pedophiles in general sex therapy practice. In Y. M. Binik & K. S. K. Hall (Eds.), *Principles and practice of sex therapy* (5th ed., pp. 219–234). New York: Guilford Press.

Carvalho, J., & Pascoal, P. (2020). Challenges in the practice of sexual medicine, sex therapy, and sexual counseling in the time of COVID-19. *Journal of Sexual Medicine, 17,* 1212–1215.

Ellis, H. (1927). *Studies in the psychology of sex* (Vol. 2). Philadelphia: F. A. Davis.

Gottman, J. M., & Gottman, J. S. (2015). Gottman couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (pp. 129–157). New York: Guilford Press.

Hald, G. M., Graham, C. A., Stulhofer, A., Carvalheira, A., Janssen, E., & Træen, B. (2019). Prevalence of sexual problems and associated distress in aging men across 4 European countries. *Journal of Sexual Medicine, 16,* 1212–1225.

Hall, K. S. K. (2019). Cultural differences in the treatment of sex problems. *Current Sexual Health Reports, 11,* 29–34.

Hall, K. S. K., & Graham, C. A. (2012). *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients.* New York: Routledge.

Hall, K. S. K., & Graham, C. A. (2020). The privileging of pleasure: Sex therapy in global cultural context. In K. S. K. Hall & Y. M. Binik (Eds.), *Principles and practice of sex therapy* (6th ed., pp. 243–268). New York: Guilford Press.

Herbenick, D., Bowling, J., Fu, T.-C., Dodge, B., Guerra-Reyes, L., & Sanders, S. (2017). Sexual diversity in the United States: Results from a nationally representative probability sample of adult women and men. *PLOS ONE, 12*(7), e0181198.

Iasenza, S. (2020). *Transforming sexual narratives: A relational approach to sex therapy.* New York: Routledge.

Johnson, S. M. (2017). An emotionally focused approach to sex therapy. In Z. Peterson (Ed.), *The Wiley handbook of sex therapy* (pp. 250–265). Chichester, UK: Wiley-Blackwell.

Kaplan, H. S. (1977). Hypoactive sexual desire. *Journal of Sex and Marital Therapy, 3,* 3–9.

Kelly, S., & Shelton, J. (2013). African American couples and sex. In K. S. K. Hall & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 51–83). New York: Routledge/Taylor & Francis Group.

Kinsey, A., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia: Saunders.

Kinsey, A., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female.* Philadelphia: Saunders.

Kleinplatz, P. J. (2006). Learning from extraordinary lovers: Lessons from the edge. *Journal of Homosexuality, 50,* 325–348.

Kleinplatz, P. J., & Menard, A. D. (2020). *Magnificent sex: Lessons from extraordinary lovers.* New York: Routledge.

Laumann, E. O., Nicolosi, A., Glasser, D. B., Paik, A., Gingell, C., Moreira, E., & Wang, T. (2005). Sexual problems among women and men aged 40–80 years: Prevalence and correlates identified by the Global Study of Sexual Attitudes and Behaviors. *International Journal of Impotence Research, 17,* 39–57.

Leif, H. I. (1977). Inhibited sexual desire. *Medical Aspects of Human Sexuality, 7,* 94–95.

MacIntosh, H. B. (2019). *Developmental couple therapy for complex trauma: A manual for therapists.* New York: Routledge.

Masters, J., & Johnson, V. (1966). *Human sexual response.* Boston: Little, Brown.

Masters, J., & Johnson, V. (1970). *Human sexual inadequacy.* Boston: Little, Brown.

Meana, M., Hall, K. S. K., & Binik, Y. M. (2020). Where is sex therapy going? In K. S. K. Hall & Y. M. Binik (Eds.), *Principles and practice of sex therapy* (6th ed., pp. 505–522). New York: Guilford Press.

Sandell, R., & Wilczek, A. (2016). Another way to think about psychological change: Experiential vs. incremental. *European Journal of Psychotherapy and Counseling, 18,* 228–251.

Scharff, D. E., & Scharff, J. S. (2011). *The interpersonal unconscious.* Lanham, MD: Aronson.

Watter, D. N. (2012). Ethics and sex therapy: A neglected dimension. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: innovations and alternatives* (2nd ed., pp. 85–100). New York: Routledge.

Watter, D. N. (2018). Existential issues in sexual medicine: The relation between death anxiety and hypersexuality. *Sexual Medicine Reviews, 6,* 3–10.

Watter, D. N. (2022). *The existential importance of the penis: A guide to understanding the sexuality of men.* New York: Routledge.

Watter, D. N., & Hall, K. S. (2020). Healthy sexuality for sex offenders. *Current Psychiatry Reports, 22*(11), 1–5.

Weiner, L., & Avery-Clark, C. (2014). Sensate focus: Clarifying the Masters and Johnson's model. *Sexual and Relationship Therapy, 29,* 307–319.

Zilbergeld, B. (1983). *The shrinking of America: Myths of psychological change.* Boston: Little, Brown.

CHAPTER 20

Therapy with Older Adult Couples

Bob G. Knight

BACKGROUND

Worldwide population aging suggests an increasing need to attend to the needs of older couples. Marriage is an important aspect of later life, with most men over 65 and not quite half of women over 65 in the United States currently married (Carr & Utz, 2020). Good, supportive intimate relationships are conducive to well-being in our older years, whereas intimate relationship strain can be a stressor itself and also worsen the impact of other stressors. Marriage contributes to older men's good physical health, and good-quality marriage supports older women's physical health (Carr & Utz, 2020).

Robert Butler, pioneering geropsychiatrist and first director of the U.S. National Institute on Aging, noted some time ago (1975, pp. 390–398) that the increased proportion of people living a long lifespan means that more people are spending long periods of time living together in marriage and are thus confronting relationship issues not frequently confronted in the past, including maintaining fidelity over decades, potential boredom, and other possible emotional changes. The approach of death may lead to re-evaluation of relationships. Couples spend decades together after their children (if any) are adults and independent and no longer need the support of family in the same way.

Gray divorce, divorce occurring after age 50, has been increasing for a few decades, even as divorce at younger ages has declined (Raley & Sweeney, 2020; also see Chapter 21 on divorce, in this volume, by Lebow). With awareness of the increased likelihood of living a long time, people in unhappy marriages may well decide to end them. Some couples apparently wait for the children to leave home before divorcing. In any case, remarriage after divorce, including gray divorce, is not uncommon. Older adults may also choose to cohabit without remarriage or to "live apart together," maintaining a close connection without cohabiting (Carr & Utz, 2020). Being coupled in later life may not mean being married per se. In this chapter, my intention is to address these types of older couples throughout, assuming that the work of couple therapy is unlikely to be very different. Thus, terms such as "marital" should be taken broadly rather than assuming that the couple is legally married. I would also note that "older couple" is meant to refer to a couple with at least one of the partners over the age of 60.

Research has not yet closely engaged with the increasing numbers of older couples. Lambert-Shute and Fruhauf (2011), who did a content analysis of a decade of articles in three leading marriage and family journals, found that only 2.8% of articles mentioned older adults or had older adults in their samples. The number of such articles had not increased since previous reviews nor was it increasing over the decade studied. On a more positive note, they did find that the articles in their review focused on older adults and their needs as compared to articles in earlier reviews that included older adults mainly as problems with which their children or grandchildren dealt.

In this chapter, the contextual adult lifespan theory for adapting psychotherapy (CALTAP; Knight & Pachana, 2015) is used as a framework for discussing ways in which couple therapy with older couples may differ from working with younger couples (see Figure 20.1). The theory, and an earlier version of it, have been used in the past to discuss a variety of individual therapies used with older adults (e.g., Knight, 1996; Knight & Satre, 1999) and also to discuss family systems therapy with older families (Knight & McCallum, 1998). It is intended to be a metatheoretical framework that can be used to adapt a variety of approaches to couple therapy for work with older couples. The components of the model are considering adult developmental changes, both positive and negative, birth cohort differences between younger and older adults, cultural differences related to aging, and social context; and specific challenges that are more common in later life (e.g., chronic illness and disability, grief, caregiving). In broad terms, these components are thought to affect the nature of presenting problems in therapy and the therapeutic relationship more than the techniques used in therapy or the process of change itself.

The chapter begins with use of the CALTAP framework for describing core aspects of older adults that potentially influence the content and delivery of couple-based interventions. Following exposition of these considerations, I describe implications of these understandings for the practice of couple therapy with older adults. Throughout the chapter, clinical illustrations highlight unique challenges and opportunities of working with this population.

CORE UNDERSTANDINGS ABOUT OLDER COUPLES

Developmental Differences

A question that arises when thinking about the intimate relationships of older adults is whether the developmental processes to be addressed are the individual ones of the partners or the development of the relationship itself. One error I have often seen therapists, and especially younger therapists, make is to assume that a 30-year marriage implies that it is a first marriage, even when the person reporting it is 70 or more years of age. Some therapists also seem to assume that any older married couple has been married since they were young adults. Being aware that even long-term marriages may be second (or higher) marriages and that older couples may be rather

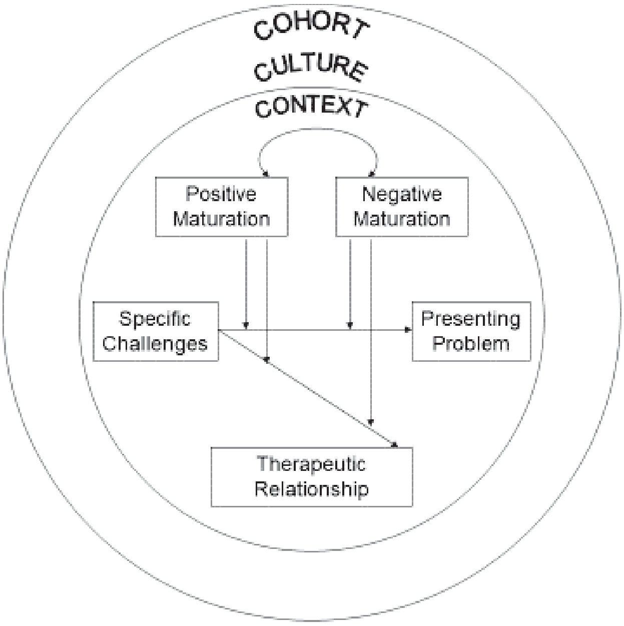


FIGURE 20.1. The contextual adult lifespan theory for adapting psychotherapy (CALTAP). From Knight and Poon (2008). Copyright © 2008 John Wiley & Sons. Reprinted by permission.

recently married is an important basic skill in understanding older couples. Both individual- and couple-level developmental influences are considered here.

Individual Developmental Influences

There are some negative cognitive changes that occur with normal aging (more severe cognitive changes with dementia are considered later when I discuss specific challenges in later life). These mainly involve basic cognitive resources such as speed of information processing, working memory capacity, attentional focus, and inferential reasoning. Taken together, they mainly result in a need to be aware of the speed of talking with older clients and with the number of ideas to be presented at once. In some instances, it is more effective to explicitly communicate therapeutic points rather than guiding clients to discover them on their own. Experience suggests that taking this pacing into account within sessions tends to mean that therapy proceeds in roughly the same number of sessions.

On the positive side, coping skills, emotion regulation, and emotional tone in general tend to improve with age. Older adults have also accumulated decades of adult life experience, including experience of their own and of other people's relationships. These strengths can be an asset in therapy and provide a knowledge base on which to draw when helping older couples work out the challenges they are facing in their relationship. These growth aspects of developmental aging can put a therapist in the position of helping older clients in couple therapy use more mature coping skills and greater life experience than they have reached themselves. That experience can be exciting or challenging, depending on the therapist's stance in therapy.

However, these positive aspects of developmental aging are relative to the individual's early adulthood coping and emotion regulation abilities, so not all older clients will show high levels of these skills. Learning from experience is often an advantage of growing older, but not everyone learns much from experience. People with personality disorders and young adult cognitive issues (e.g., attention-deficit/hyperactivity disorder) also grow older!

MEMORY

That said, long-term couples experience a lot of time together that is quite complex and diverse. All human memory is limited and selected. Some older couples can get quite caught up in arguing about whether particular events happened in the rather distant past or about the fact that they remember some events differently. Combined with the anxiety that many older adults feel about more serious memory loss, these arguments can become rather intense. Some psychoeducation about the incompleteness of human memory and the futility of trying to determine the truth about past events by argument can be useful with older couples who get caught up in these arguments. And, of course, these memory issues may increase with further aging, so the acceptance of memory lapses is important for the future as well as the present.

SEXUALITY AND INTIMACY

A more emotionally charged issue for older couples is changes in sexuality with aging. Sex can continue for older adults throughout the lifespan and often quite happily (Shaw, 2012; Willert & Semans, 2000). Changes in sexuality may mean a need to change long established habits in the ways that couples express physical affection and arouse one another. This can be difficult for couples who have not been in the habit of talking about their sexuality.

For men, the changes typically include a lowering in the urgency of sexual desire. Several older male clients have expressed this as feeling that they are in charge of their sexuality rather than their sex drive being in charge of them. It may require more stimulation from their partner to get and maintain an erection and losing and regaining erections several times during intimacy is fairly common. Men may also experience ejaculation and orgasm separately.

Some women may take menopause itself or physical changes related to menopause as a signal that it is time to cease sex. Other women seem to find menopause freeing where sex is concerned, and the hormonal changes may increase desire for some. Vaginal lubrication may lessen and there can be thinning of the vaginal wall that can lead to painful intercourse. There are potential interventions to reduce these symptoms, including vaginal lubricants and hormone replacement therapies.

Diseases common in later life can lead to other sexual problems for both men and women. Medications have a variety of side effects, with some medications reducing sexual desire and others leading to the drying of tissues throughout the body.

The changes can cause even more difficulty if taken as a sign of transition into asexual old age. Older men may take changes in the timing of erections or the amount of stimulation needed to get and maintain an erection as a sign of impotence. Ageism regarding sexuality is especially frequent and pervasive in society. As noted by Muruthi, McCoy, Chou, and Farnham (2018) changing cognitive scripts based on ageist sexual attitudes can be a key element of couple therapy with older adults. It is essential that couple therapists be knowledgeable about sexual changes with age and comfortable talking about sex with older adults.

These negative attitudes can also be conveyed and given official sanction by health professionals of various disciplines. In a particularly dramatic example, I once saw a couple after the husband's brief stay in an inpatient psychiatric unit following a suicide attempt. He was extremely depressed because he had been told by friends in a coffee group and then had it confirmed by his physician that people over 70 should not have sex. He and his wife reported having had sex more than once a day throughout their marriage. On being told that the idea that sex stopped in later life was simply wrong, they resumed their sex life, his depression lifted quickly, and their marital satisfaction returned to its high baseline level. While obviously an extreme example, it illustrates vividly the potential impact of age stereotypes about sexuality in late life, and the potential improvement when they are corrected.

It remains fairly common to have sexual changes or difficulties attributed to aging and therefore perceived as not changeable. Educating older couples about the remaining possibilities for enjoyable sex and how to achieve them has been the occasion of some of the most rapid and dramatic changes in relationship and life satisfaction I have seen over the years. A good resource for further information on sexuality and aging is Jennifer Hillman's *Sexuality and Aging: Clinical Perspectives* (2012). It should be noted that sexual disorders as such can occur in late life and may need referral for sexual therapy (Syme, Cordes, Cameron, & Mona, 2015; also see Chapter 19 on sexuality, in this volume, by Hall & Watter).

I recall a clinical colleague being astonished when I shared during peer consultation the sexual history I had taken from a couple in their 70s who had come in with a presenting problem about their sex lives: "You asked old people all those questions about sex?!" I asked if that was not what you did with that presenting problem and he acknowledged that it was, and also that he could not imagine asking people 30-plus years older than himself about sex, but that he needed to learn to do that. I have noted frequently since that time that most people (including therapists) have taboos about talking with older people about sex, especially people old enough to be their parents or grandparents. And some find repugnant the idea of older people whom they would find unattractive having sex. Overcoming these common barriers to effective work in this space is obviously essential to good work with older couples, but it is also quite difficult for many therapists. To a large extent, this is a matter of practice and getting past the initial discomfort. For those whose discomfort is not handled by practice, self-reflection on why talking about sex with older people is uncomfortable and discussion with clinical supervisors competent in work with older couples can be quite helpful.

For more detail on the individual developmental changes described in this section, see earlier work on the CALTAP model (e.g., Knight & Lee, 2008; Knight & Poon, 2008).

Developmental Changes in Relationships

Much of what we know about developmental changes in couple communication and conflict comes from work in the 1990s by the research team comprising Laura Carstensen, Robert Levenson, and John Gottman. They found that "young-old" couples (60–70) tended to resolve conflicts with less negative emotionality, less psychophysiological arousal, and more affection than middle-aged couples (ages 40–50; Carstensen, Gottman, & Levenson, 1995; Levenson, Carstensen, & Gottman, 1994). These findings suggest that relationships may improve with age, with similar changes in emotion and coping styles as with the individual members of the couple.

In their summary of this research, Carstensen, Graff, Levenson, and Gottman (1996) suggested a curvilinear developmental pattern for marital satisfaction: starting with high satisfaction, a decline in the childrearing years, and a rise in the empty nest years. They noted that some conflicts between couples resolve over time, while the ones that continue become more predictable and less threatening. Ayalon and Koren (2015), in their summary of the developmental pattern of marital satisfaction, note that there is a range of evidence on this point and time-related influences include marital duration, age of the partners, and cohort influences, among others. Some prospective longitudinal research suggests decline in ratings of marital quality with duration of the relationship, but with the age of the couple being associated with higher quality. This difference in effect between the duration of the relationship associated with lower ratings of quality and the age of the couple correlated with better quality again points to the importance of attending to both the age of the partners and the duration of the partnership.

Cohort Differences in Couple Relationships

Lifespan developmental psychology and scientific gerontology call attention to cohort differences that often explain differences between younger and older people at any given point in time. Cohort differences (often referred to as "generational differences," especially in popular media) result from the sociohistorical influences on birth cohorts of people. They are the influences that distinguish the World War II generation from Baby Boomers from Millennials and so forth. While developmental differences are ways that couple relationships change over the life course of the people in them or over the course of the relationship itself, cohort differences are the ways in which the relationships of people born at different points in time are distinct from one another. These differences and therapist competencies needed to understand and respond to them are roughly analogous to cultural differences. In order to keep clear the language used to discuss them, it can be helpful to refer to cohorts as later born and earlier born rather than young and old.

The typical age at which people marry differs between cohorts. For Americans coming of age around 1950, the average age of first marriage was about 20 for women and 23 for men; for the cohort reaching adulthood in 2000, it was 24 and 26, respectively, with the proportion marrying at all declining over those cohorts as well (Schoen & Canudas-Romo, 2005). Baby Boomers have had particularly high rates of divorce. Cohorts born after the Baby Boomers have tended to marry and divorce at lower rates, being more likely to cohabit and less likely to marry due to pregnancy (Raley & Sweeney, 2020). Attitudes toward same-sex marriages have changed over time with the influence of the gay rights movement and have also evidenced cohort differences, with later born cohorts being more accepting of same-sex partnerships and marriage than the earlier born, thus reducing some external stress on same-sex couples (Ayalon & Koren, 2015; Goldsen et al., 2017; see also Chapter 23 on queer couples, in this volume, by Coolhart).

Attitudes and values around marriage among older couples in therapy can also be quite different by birth cohort. When first working with older couples in the 1980s, I discovered that earlier born cohorts did not necessarily expect marriage to bring happiness and personal development, often approaching marriage with a more pragmatic attitude and a sense that a marriage without major problems such as alcoholism or abuse was successful. Couples marrying during World War II often married after knowing each other for short periods of time, were separated for a few years, during which children conceived during home leaves were born, and then resumed married life with children when the war ended. Couples marrying in the 1960s and 1970s were more keenly aware of gender roles and were renegotiating traditional roles in ways not typical for earlier born generations. These are examples of cohort differences among cohorts that are now older adults.

Being aware of cohort differences in marriages and alert to how one's own cohort attitudes and values may differ from those of older couples can be very helpful in forming rapport with couples and shaping the course of therapy. For couples with significant age differences between partners, understanding the effects of the difference in terms of cohort effects rather than developmental aging can be helpful. Cohort differences imply less evaluation than one partner being more mature than the other and thinking in cohort terms can often reframe differences in less personal and judgmental ways. Seeing things differently because of having been raised in different time periods is relatively value-neutral.

A Boomer married to a World War II partner may have higher expectations of emotional communication and for marital quality than the earlier-born partner. The earlier born partner may have more traditional gendered expectations of how household responsibilities will be handled. While these differences are obviously of significance to the relationship, framing them in cohort terms can improve mutual understanding and put the differences into a wider social and historical context that can make compromise easier than if it they are construed as old-fashioned versus immature or simply as "I'm right and you're wrong."

Later born therapists may also be surprised by cohort differences in how clients formed relationships in their earlier born cohorts. For therapists raised in times when cohabitation is accepted, pregnancy does not automatically mean marriage. And with social acceptance of gay and lesbian relationships, it may be surprising and difficult to understand and accept why earlier born clients married young in order to have sex, married someone because of pregnancy more than choice, or to encounter gay and lesbian clients in opposite-sex marriages or with ex-spouses of the opposite sex who are part of the couple therapy issues.

In terms of differences that arise in working with older gay couples, many of these are likely to be cohort related. The gay rights movement started when Baby Boomers were young adults, and the broader social acceptance and the policy changes have spread unevenly through the world since that time. Couple therapists need some understanding of the circumstances in which the couple grew up to understand potential differences in their perceptions of being gay and what they have experienced in relationships.

Learning to "think cohort" as an alternative to attributing all differences between younger and older couples to age and thus developmental differences is an important lens through which to view older couples. Thinking cohort can also help later born therapists comprehend their clients' reviews of their relationship and to understand their own cohort-based biases.

Culture and Couple Relationships

In ways roughly similar to cohort differences, cultural backgrounds affect couple relationships as well. Norms about age at marriage, cohabitation without marriage, and values and attitudes about marriage and divorce can all differ by cultural background. Even whether marriages are based on love or are better done by arrangement between families differs by cultural background. With respect to older marriages, it is important to keep in mind that culture and cohort interact: Couples from different cultural backgrounds have distinctive cohort trajectories as well. For example, older couples from some East Asian countries have experienced within their lifetimes transitions from relatively poor agricultural economies to wealthy technology-based economies, as well as from traditional values to globalized Western values. As with cohort, competency in being attuned to clients' cultural background and to ones' own cultural values around marriage is an important aspect of building rapport and planning and carrying out couple therapy (also see Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim).

Cultural differences within couples can pose their own challenges. Pete was in his early 70s and Joyce in her mid-60s when they came in for couple therapy. He was third-generation Mexican American, and she was from a Scandinavian cultural background. It was a second marriage for both. One of several areas of conflict for them was the relationship with his family, which was not accepting of her as a replacement for his first wife and because she was not of their culture. Both agreed that his family could be quite confrontational and impolite to her. He would add that they were confrontational in general, including with him. Both were quite upset about his family's treatment of her. He also had other issues with his family. They mostly dealt with the situation by having Pete go to family gatherings without her. He respected her decision, but she failed to understand why he continued to attend these gatherings. Over several sessions with some review of both of their family backgrounds, they came to an understanding that their conflict had its roots in their different cultural backgrounds. Pete felt that family was of central importance in life regardless of how you felt about them or how they treated you. Joyce had come from a more individualistic family background, with little expression of affection or of conflict and a pattern of avoiding unpleasant family members, so she felt the tension with his family even more intensely than he did. They were also hampered in perceiving these differences by their cohort/cultural backgrounds: He had been raised in a time and neighborhood that emphasized the separateness of being Mexican American and viewed Anglo culture as something a bit strange and of limited interest. She not only was from a particular type of Anglo culture but had also been raised implicitly to ignore cultural differences (i.e., to be "color-blind" as an ideal).

Within the limited literature on older couples, there is scant attention to cross-cultural marriages among older adults. As with cohort, applying cultural competency to older couples and understanding how culture and cohort interact to shape the experience of older cross-cultural couples is an important aspect of good clinical work with older couples.

Social Contexts

Within the CALTAP model, "social context" refers to the local social settings in which older adults may find themselves, as well as the social rules and norms that have particular impact on older adults. These can refer to aged care facilities, retirement villages, even health care services that occupy more of many older adults' lives than is true for younger adults. These can also refer to social structures such as retirement, to laws around elder abuse, and to other public policy affecting older adults. With regard to couple relationships in late life, the impact of retirement is quite salient, and entry into age-segregated living can also have significant impact on the relationship.

Retirement

Retirement and a couple's relationship affect one another. Discussions of the course of marriage over the lifetime frequently mention retirement as an influence on marital quality (e.g., Carstensen et al., 1996), and discussions of adjustment to retirement mention marital quality as an influence (Sterns & McQuown, 2015). Retirement affects couple relationships by increasing the amount of time that partners are together during the week if they retire at the same time or if one of them has been a stay-at-home partner. This may be experienced as positive or negative, depending on how much they enjoy each other's company. The decrease in time spent working outside the home can also be the occasion for renegotiating household duties that were based in part on the nature of the retiree's former work schedule. The newly retired person may also have more time to notice things around the house and comment on how things are done.

Planning for retirement is limited in general and much of what is done focuses on financial planning rather than planning postretirement lifestyle (Sterns & McQuown, 2015). Over the past few decades, the nature of work and retirement has changed considerably with increased flexibility about age of retirement, working after retirement, second careers, and so forth (Sterns & McQuown, 2015). While the flexibility is generally positive, the number of decisions that couples face as retirement approaches has increased a lot and opens the potential for disagreements around the timing and nature of retirement. Some couples coming in for therapy at this time may have discovered that they have quite different ideas about postretirement life: One may have assumed that there will be a lot of travel in the retirement years, and the other may be looking forward to quiet down time at home or spending a lot of time on the local golf course.

A common issue is working out how much time the couple wants to spend together versus how much individual time each of them wants and needs. As one colleague commented to me: "I married my husband for life but not for lunch. I want him out of the house in the middle of the day." While some couples work out this balance well without help, there is potential for conflict or misunderstandings and hurt feelings. One member of the couple may have a higher desire for togetherness and see the other's desire for time alone as rejection. The other may perceive the demands for time together as overwhelming dependency.

The couple's relationship may come under even more stress if both persons work outside the home, and one retires substantially before the other. Having one's partner staying home and relaxing while one goes to work can feel unfair. The retiree may feel hampered in enjoying retirement by the worker's schedule, for example, wanting to take long holidays that the worker is not able to do. The retiree may have different ideas than the working partner as to the timing of their retirement. Starting these discussions about their different perspectives on retirement in couple therapy and exploring whether long-held ideas about retirement need to change, either because of broader societal changes in the nature of retirement or in order to have the couple's relationship work well, can be important elements of work with older adults. The role of the therapist is likely to be encouraging open communication and working on compromises. Part of therapy with older couples around retirement issues also may be helping them to see retirement as a socially constructed context for their lives and one that has changed a lot over time. Some people are inclined to see retirement as a developmental life stage and thus potentially difficult to change.

Retirement and the resultant increase in time spent together and the need to renegotiate how the relationship works can, of course, bring to the surface long-standing issues that have been on hold for years or decades, with one or both people being able to tolerate the previous balance in part because of the limits on time spent together or an understanding of shared housework based on the work outside the home that one of them has done. In these cases, review of the relationship and recognition that things have changed for both and that this is a time to create new arrangements becomes a key part of the therapy.

The discussion so far has largely focused on planned and voluntary retirement; however, not all retirement is entirely voluntary. While laws against age-based discrimination in the workplace may prevent workers being terminated explicitly due to their age, it is not uncommon for workforce changes to favor younger and lower-paid employees over the older workers. Some employers find ways to pressure older workers on the job, so that they take retirement rather than remain in an increasingly stressful work environment. Clients may be sensitive about the circumstances of an involuntary retirement, and it is important to be alert to the possibility and to explore it as an issue for the retired worker and for the couple.

One couple I saw was, among other issues, confronting fundamental disagreements about the husband's retirement. Several years prior, his role at the company he worked for changed dramatically and shifted from work that he liked to work that he did not feel fit his personality and skills. The change was described as being due to broader changes in the local economy and resulting changes at his company. He felt that retirement was the only way out of a bad work environment. His wife had no desire to retire from her job. She also felt that he was doing very little as it was and questioned what life would be like for them if he did not have work keeping him somewhat busy. A related factor was that she was now making more money and had more in her retirement fund. He felt that his support of her and the children earlier in the marriage entitled him to be supported by her to some extent late in life. She was not happy about that and cited several examples of what she perceived as his problems in managing money. Couple therapy gave them some space to discuss these and other issues more than they did at home. It became clear over several sessions that they understood each other very well and generally agreed with each other's perceptions of the situation. On the other hand, neither of them was motivated to compromise. He did retire and after some time for adjustment, they worked out an arrangement that was more truce than resolution.

A significant proportion of retirements among older adults may actually be due to disability. When one is old enough and has enough work years to take age-based retirement, it is typically easier to take retirement. Couple relationship issues around the disability itself are addressed in a later section. However, an important point to note here is that couples using the retirement language may not communicate clearly to the therapist that there are disability issues as well. Some couples may not be addressing with one another the changes due to the changing abilities of one partner.

Age-Segregated Living

While the proportion of older adults in any age-segregated living arrangement (from independent living retirement villages to nursing homes) is fairly small, the lifetime likelihood of spending some time in one is more substantial. At the independent end of the spectrum, it may be a lifestyle choice or to some extent based on future expectations of need for services if additional care is offered. Much of the impact of age-segregated living arrangements on couples in the higher care range will be about the changes caused by the disability that makes the care necessary. These aspects are covered in the section on specific challenges of later life. Here, the focus is on the ways that the social context of these settings can affect the couple's relationship.

Older couples can make the decision to move to age-segregated living environments for a variety of reasons. If a couple in therapy is considering such a decision, it can be helpful to explore what they hope to get from the move and how much evidence they have that the places being considered will meet those expectations. If the therapist sees a lot of older couples, it can be helpful to have a sense of what is available in the community to give more depth to these discussions. Being able to advise couples to be clear on how much guarantee they have of access to higher levels of care can also be helpful in their decision making.

Decisions about higher levels of care are largely influenced by the physical frailty or cognitive decline of one or both partners. The decision of when to move from home care to residential care can be difficult and involves personal decisions around what can be done by the more able partner, what home health services are able to provide, and the relative cost. Home care can be less expensive when relatively little support is required, but when the need for care approaches 24 hours per day, residential care is likely to be less expensive. Again, the couple therapist can play a role in helping partners discuss the pros and cons clearly with one another in the context of their own values. In many communities, nursing homes are full, so advising clients that they may need to get on waiting lists months or years in advance may be quite helpful.

At the independent-living end of the spectrum, the social context issues are most likely to revolve around how each partner adjusts to being in the group living situation with more interaction with others and being frequently watched by others. If there are group meals, the scheduling and quality of those meals and interactions with people who share their table become a new part of the relationship. In general, there are more single women than single men in later life, and some of those single women are likely not opposed to relationships with married men.

One older couple that lived in a small independent living retirement village came to see me over conflicts related to the wife's jealousy. Her husband was quite handy and often did home repairs for widows living in the village. He saw this as a way to pass the time and be helpful to neighbors. His wife did not trust the intentions of some of the women and was not entirely confident of her husband's fidelity. As we talked in more detail, the wife had a fairly convincing case that one widow in particular had a rather high frequency of needed repairs and always had something to feed her husband or drinks ready when he was done. The husband tended to minimize his wife's concerns, seeing the woman's attentions as "just being neighborly." With some sharing of perceptions and emotions, the conflict was eventually resolved, with him agreeing to no longer help that woman and her agreeing on which others in the village he could help without worrying her.

In multilevel care environments, it may well happen that one person in the couple will need a higher level of care than the other, and this can lead to separation of their housing arrangements. The couple will then be constrained by rules about visiting hours and potentially other policies that can vary by specific setting and sometimes within settings, depending on which staff members are on duty. Although the degree of acceptance of residents' sexual needs when in care has increased in recent years, some places still prevent sexual activity, even between married partners. The level of acceptance of sexual activity is unfortunately even less likely for same-sex couples. Even when sex is permitted, the relatively public nature of it (given that everyone will know which room is used for conjugal visits) and the need to make specific arrangements can be challenging. These issues can also arise, of course, for older couples living in the community when one must go into supported care.

While more older adults live on their own in the broader age-integrated community, for those who do enter age-segregated settings at various levels from independence to high need for care, the social ecology of those settings influence their lives and their ability to maintain their relationship. Understanding these settings from the clients' viewpoints and the reality of the issues they face is an important aspect of working with older couples. Moreover, it may be important to consult with staff in the facility to reduce undue barriers to couples pursuing specific relationship needs—especially if partners are receiving different levels of care.

Specific Challenges

Chronic Illness, Disability, and Caregiving

When the CALTAP model is applied to individual psychotherapy with older adults, caregiving is discussed separately from chronic illness and disability. When working with couples, however, the two go together because one partner's becoming functionally impaired to some degree will generally mean that the other person becomes a caregiver. Their relationship then changes in multiple ways as the couple adjusts to no longer being two healthy and able people relating to one another. Although the nature of the changes will be different with the particular nature of the illness and disability, most illnesses in later life are chronic and many are progressive. Physical frailty will change the relationship to some degree; the changes with progressive dementia and the resulting loss of cognitive functioning yield even more dramatic changes. In this section, the focus is on issues in couple therapy when one or both partners have significant functional losses due to chronic illness. Readers unfamiliar with working with individuals with chronic illness and disability or with caregivers for frail older adults would be advised to study the individual and family systems approaches as well (e.g., Knight, 2004; Knight & Pachana, 2015; Qualls & Williams, 2013).

Changes in the physical or cognitive abilities of one partner result in the need to alter long-standing patterns of behavior and understandings of who is responsible for which tasks in the home. Working with couples experiencing these changes requires knowledge, skills, and personal comfort on the therapist's part in guiding therapy conversations about chronic illness and resultant disability, and their impact on couple relationships.

PHYSICAL FRAILTY

People often do not handle well the diagnosis of serious illness and the loss of some healthy functioning in themselves or in their partner. Some degree of denial is not uncommon, and couples can also fall into a pattern of not talking to one another about the changes because each is feeling emotional about them, likely in different ways.

The partner with the illness is dealing directly with the personal effects of the illness, any resulting loss of abilities, and, in some instances, with confronting the prediction of a shorter lifespan ahead. The other person is coping with caring for an ill partner, the loss of the partner's abilities and resulting shifts in household duties, and the possibility of widowhood. While these effects of the illness or disability are related, the perspectives can be quite different. Helping the partners to communicate about how each is perceiving the issues and working on a joint plan for handling these is a key element in therapy involving illness and disability.

While I was in training, I was part of a research team that observed, among other groups, a support group for people with cancer and their spouses. After attending a number of sessions in which there was very little support happening, we asked for and received permission to intervene in the group's process. The first thing we did was to put the people with cancer and the spouses into separate rooms. They immediately started sharing their pain, their experiences with cancer or with their spouses' cancer, and being supportive of one another (Wollert, Knight, & Levy, 1980). Everyone in both groups said they were unable to bring the topic up because they did not want to upset the spouse. After a few separate sessions, we brought them back together and they were able to talk in front of spouses and with their spouses at home. Working with couples, it may well be necessary to have some separate meetings to work through these types of concerns before being able to have open conversations in the conjoint sessions (Baucom, Porter, Kirby, & Hudepohl, 2012; also see Chapter 28 on medical issues, in this volume, by Ruddy & McDaniel).

A couple in their 70s who came in for therapy first made contact when the wife came in for stress related to caring for her husband, who was diagnosed with chronic obstructive pulmonary disease. She was concerned not only that he was not following medical advice to use his oxygen but also that he was not doing as much around the house as he used to do. He came in for therapy when they began arguing about the wisdom of an out-of-state trip he wanted to take. They were seen in an agency setting in which it was feasible to have both individual therapy with separate therapists and conjoint sessions involving the couple and the two therapists. Both were in denial about his illness and its effects. Both resisted the idea of having others do more strenuous household tasks, so he either went ahead and did them, resulting in health crises for him, or else she took on the tasks, which worsened her health. In one instance, she had a stroke while mowing the lawn.

In conjoint therapy, they negotiated a modified plan for the trip that they felt they could handle. Between individual and joint sessions, he used his oxygen more regularly and they cut back on expectations for what they would do around the house. Not long after their return from the trip, we found the husband in the waiting area with grayish skin and labored breathing. In discussion with them, we discovered they felt their physician was underestimating worsening in his condition, including his recent perception that his lungs were blocked. They sought a second opinion and discovered he had advanced lung cancer. Like the self-help group members, they were generally unwilling to discuss between them his illness and the likelihood that he would die soon, so most of the therapy beyond this point involved individual sessions; however, there were some sessions in which they were able to talk through her concerns about financial issues after his death, which to her surprise he had already considered. He was quite willing to make changes in his will and estate planning to protect her. They had separate children from previous marriages. In fact, they had been in-laws, previously having married siblings who died within a couple of years of one another. This further complicated family issues, emotional and practical. This example also touches on grief and stepfamily concerns, which I address more directly later in this chapter.

A common theme is the concern of the person with impairments that they are too much of a burden for their partner. While the reality of this concern can be quite variable in general, among couples coming in together for therapy, my experience has been that most (not all) spouses see the care as part of the ongoing loving relationship and find the work of caregiving less burdensome than the frail person imagines. In most instances, bringing this topic into the therapy conversation reassures the partner with disabilities that the other partner is not feeling overly burdened or overwhelmed. When there is an element of the partner having difficulty with the care, some problem solving about alternative ways of handling some tasks (e.g., home health and personal care services) or prioritizing what needs to be done and how often is helpful.

A key issue for couples dealing with progressive disability in one partner is what happens with their sex lives. There are instances, although actually fairly rare, in which sex may be physically risky or no longer possible. It is generally worthwhile checking what specifically the couple has been told by treating physicians, since there are often incorrect assumptions made by the couple without factual information. As with other issues with disabilities, encouraging communication is an important first step in resolving the issues. Since both the illness and sex may well be topics not much discussed by the couple, it may well develop that the issues about reducing or eliminating sex in their lives is more in the imaginations of one or both partners, with both more concerned about the medical issues. The conversation also often leads to finding ways to express physical affection and comfort in the relationship that do not involve intercourse. In some cases, alternative ways to orgasm that are still physically possible are part of the solution.

In one instance, a husband going through a geriatric assessment mentioned late in the process that he was quite frustrated about the end of their sex life due to a surgery he had had that involved replacing part of his bladder with tissue from his intestines, with a resulting discharge of fluid through his penis. We suggested that some sessions in couple therapy could be helpful in exploring options for their sex life. As it happened, bringing this up in the assessment feedback session triggered the first conversation they had about this issue. They told me later in an informal visit that each had assumed that the other would not want to have sex under the changed conditions. The wife had also assumed that he was perhaps no longer able or interested. They first resumed sex using condoms due to the discharge, then fairly quickly decided that the discharge was not objectionable. In their words, "We're going at it like teenagers now!"

DEMENTIAS

While physical illness and related disability are quite significant challenges for older couples, cognitive decline resulting in disability can be even more challenging. Most of the dementias of later life are progressive, and they eventually considerably reduce and then eliminate the ability of the partner with dementia to participate in the relationship. For the other partner, the experience is a slow loss of one's partner while they are still alive.

"Dementia" is a general term referring to decline in cognitive functioning. In the text revision of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2022), the term has largely been replaced by "neurocognitive disorder," with dementia still recognized as a term in wide use for late-life-onset disorders. The most common is Alzheimer's disease, which has a slow, progressive onset. In the media and often in professional writing, dementia is used as a synonym for Alzheimer's, and the other dementias of late life are sometimes ignored. The others are vascular dementias, Lewy body dementias (related to Parkinson's disease, in that Lewy bodies in the brain are common to both), and frontotemporal dementias. (There is also a wide range of other causes of dementias in late life that each occur much less frequently.) Whether strokes and other cerebrovascular changes result in cognitive decline depends on the part of the brain affected, and the same is true for Parkinson's disease.

One couple that I saw had recurring arguments about events that happened years and sometimes decades ago, as well as arguments over misplacing things in the house. They blamed each other for things not being in the usual place or for things not being where they remembered leaving them. Memory was a very salient issue between them. Neither partner appeared to have serious cognitive impairment in session and neither reported typical signs of serious impairment in themselves or the other. We had separate sessions in which I gave each of them a Montreal Cognitive Assessment (MoCA) screening test and talked further about issues around forgetfulness they saw in themselves or in the other. With permission from both, the results of the MoCA and my impressions of their memory levels were shared. Both had scored in a range that would be consistent with mild cognitive impairment, although the husband's score was worse and in the borderline area between mild cognitive impairment and early dementia. The wife's cognitive loss was milder and in line with normal aging changes. With this evidence that memory was an issue for both, I encouraged them to avoid arguments about memory and to not debate memories of events that were more than 3 months old. This strategy lowered their level of arguing quite a lot, and we went on to explore other issues in their relationship.

This example illustrates some of the issues in working with a couple in which one or both partners are experiencing significant memory loss or other cognitive decline. A key issue is being able to assess, or able to refer to someone who can assess, the degree of the memory loss and its likely association to daily functioning and related conflicts in the relationship. Even when the couple comes in knowing the diagnosis, help in applying that knowledge to daily experience is likely to be needed. Being able to model and encourage open communication about the cognitive impairment and likely ongoing decline is a useful skill in working with these couples. Many couples coming to therapy will be coping with cognitive decline (as noted earlier with physical disabilities) by not talking about it. In many cases, guiding the couple through problem solving about ways to cope with the cognitive disability will be another important aspect of the intervention.

A couple in their early 70s came in for therapy not long after the husband had been diagnosed with Alzheimer's disease and was still in the early stages of the disease. They were having some difficulties talking about the diagnosis and what it meant for them on their own. The wife was not feeling ready to talk about future plans, and the husband was feeling the need to do so before cognitive decline made it more difficult. They also had some disagreements about planning for future care, in that the husband was very concerned about the potential adverse effects on his wife, and she was feeling committed to taking care of him at home no matter how bad it got. The sessions focused on both partners sharing thoughts and feelings about the diagnosis and how it was changing ideas about postretirement life. There was discussion and planning about what they could realistically do soon, so that they could be assured of having the chance to realize those plans at all. They had preliminary discussions about what each of them saw as the appropriate level of functional disability that could prompt seeking additional in-home assistance and 24-hour care.

Grief

There are occasions when grief for a child or grandchild who has died emerges as an issue while working with an older couple. Having a child die is always a traumatic event, and this is no less true when the child is well into middle age or older. Older couples often perceive friends and family to be less sympathetic to their loss of an adult child than is seen to be the case when younger children die.

Grief work in general takes the dual-process form of going through the range of emotions that grief evokes and adjusting to life without the deceased in it (Stroebe & Schut, 1999). As a couple issue, the themes often involve perception that one's spouse is not grieving enough, does not understand one's own loss, or is not being supportive, among other potential issues. Providing a space for talking about the death together and helping the couple understand one another's grief reactions are common parts of therapy in this situation. Grief work also often involves a review of their life as a couple, the place of the deceased child in their lives, then looking toward the future without that child. There may also be discussion of how their surviving children are handling the loss and how they might take the lead as parents in helping the family grieve as a whole.

Another way that grief arises in therapy with older couples is that remarriage after the death of a spouse is fairly common, especially for older men. If the remarriage occurs before the survivor has worked through grief, the deceased spouse can become a part of the new relationship. Comparisons of a current partner to a former one are seldom a positive aspect of a relationship. They can be especially difficult when the grieving partner is inclined to remember the deceased spouse in very positive terms, a common phase in the grief process. There can also be practical issues surrounding how many physical reminders of the deceased are present in the house that the couple occupies, contact with in-laws related through the deceased, and so on. Working on how to strengthen and affirm the new relationship without expecting the grieving partner to erase past history with the deceased spouse can be an integral part of couple therapy. In general terms, the couple therapist can play a role in encouraging the couple to discuss their reactions openly and potentially helping to work out compromises around the practical issues.

One couple in their mid-70s began therapy with a presenting problem of frequent arguments about household tasks, largely based in the husband's complaints about the way the wife was doing different types of housework. As we explored these arguments, it emerged over the first few sessions that the complaints often took the form of comparing his wife to his previous wife who had died less than a year before the couple started living together. They were both widowed, although she had been a widow for 6 years before the current relationship started and her husband had died after a long illness that required extensive caregiving on her part and also allowed for anticipatory grief. She felt that there were essentially three of them in the relationship, including the deceased wife. She stated in the sessions that she thought it was essentially impossible to compete with a ghost for her husband's affection and esteem. He was taken aback by his wife's perception of what was happening and acknowledged that he was doing this comparison, although not intentionally, and out of discomfort with things not going as expected, without fully realizing himself that those expectations were grounded in a 40+ year marriage to a different woman. In the conjoint sessions, they worked on ways to develop a mutually agreeable approach to household tasks, and he volunteered to reduce comparative comments. He also agreed to attend individual sessions to deal with this grief for his deceased wife, recognizing that he had rapidly remarried rather than grieving after her death. He was clear with his current wife and the therapist that he was quite happy with the current relationship.

Stepfamilies

Stepfamilies formed earlier in life can have issues that continue well into the old age of the parents, and these should certainly be explored as needed (also see Chapter 22 on stepfamily couples, in this volume, by Papernow). However, the principal focus here is on stepfamilies that are formed when the couple is older and the children from prior marriages are well into adulthood. Even children who have grown children of their own can have complex emotional reactions to older parents falling in love and marrying someone else. It is not uncommon that they are very uncomfortable with the discovery that their parent is still sexually active. They are also perhaps even more likely than younger children to feel entitled to give parents strongly worded advice or even make demands. It can be uncomfortable for the partner and put a strain on the relationship if one or more children's reaction to the new marriage is so severe that it strains the relationship between parent and child.

These emotional reactions can often be complicated by concerns about inheritance. Indeed, an issue for the couple to consider is how they want to set up inheritance arrangements and how to communicate these to the children in ways that can minimize their concerns. Each person in the couple may also have concerns about what happens to their living space when the partner dies. If it goes immediately to their children, the surviving partner may then have to move while acutely grieving. It can also be wise to have some shared understanding (between the couple and also with all involved children) about whether inheritance changes if one partner spends years caring for the other through a progressive illness.

Specific Opportunities

Late-life relationships are sometimes relatively free from the pressures of relationships earlier in adulthood. Given reasonably good health and an adequate retirement income, couples are freer to pursue their interests. In spite of the common wisdom about empty nest marriages being a source of stress, population-level studies suggest that having children leave the home results in improvements in both individual and marital satisfaction (e.g., White & Edwards, 1990). Similarly, being free of the time demands and other stressors associated with employment is a plus for many couples.

Later life can thus provide time and freedom for couples to pursue both individual and shared interests. They may find pleasure in travel, volunteering, time with family (especially grandchildren), getting to know one another again, and greater opportunities for romance and intimacy.

Couple therapy, of course, tends to be with people experiencing difficulties with their relationship. It can be an important counterweight to societal ageism and stereotypes about older people's relationships for therapists to take opportunities to meet and get to know happy older couples. This can be especially useful for younger therapists who may not have direct experience of long-term relationships or of new relationships among older people. It can also be a help to older therapists who may be inclined to take their own experience as an indicator of what is normative in later life relationships.

PRACTICE OF COUPLE THERAPY WITH OLDER ADULTS

Structure of Couple Therapy

Older adults can come into couple therapy in a variety of ways, including seeking couple therapy because they have had helpful couple therapy in younger years, direct referral for couple work in later years, and individual therapy transitioning into couple work as their relationship emerges as a key aspect of the presenting problem (Rosowsky, 1999; Wolinsky, 1990). These earlier authors suggested that older adults are less likely to see couple therapy as an alternative and so are more likely to start with individual therapy and transition to couple therapy at the therapist's suggestion. To date, there is no evidence on this point or whether it was a cohort phenomenon and may have changed since the 1990s. Given the centrality of the couple relationship in adults' lives at all ages, combined with the usual relative decrease of other potential stressors (work, raising children to adulthood), the couple relationship may be more likely to emerge as a key focus of concern for individual older adults seeking psychotherapy.

For example, an older male client with a 10-year history of depression came in for therapy, struggling with concerns about his work and whether to continue an unpleasant job or retire. It quickly developed that a key element in his ongoing depression was his marriage: a sense of criticism and demands from his wife, and the absence of affection. At my suggestion, she joined the therapy to focus on improving their relationship. As it turned out, she was also very distressed and under pressure from her work and caring for her frail mother, as well as being distressed by their relationship. We continued for some time with individual work for each of them, as well as couple sessions, with a focus on handling other stressors in their lives but within a couple therapy framework and an overarching focus on their relationship.

Approaches to systems therapy (couple and family) often advocate for separation of the systems approach from individual therapy. Work with older couples has departed from this to some extent, in part due to the scarcity of therapists working with older adults in any modality. Also, as noted in the prior sections on working with couples confronting physical or cognitive frailty, there are issues arising in later life that some couples will not discuss with the other person present until they have had opportunity to work this reluctance out with the therapist. Systems and individual approaches can lead to differing therapeutic goals, and it is important to discuss the potential differences in the approaches with clients before moving from individual to couple therapy or vice versa. It is also of critical importance to be clear what the understanding about confidentiality of information shared in the individual session vis-à-vis the couple session. My own stance has been that I do not want to know information that I cannot use in the couple session. Others have differing stances on this question (see Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen).

When working with a couple facing serious physical disabilities that progress into terminal illness for one of the partners, couple therapy may transition to individual therapy when one person becomes too ill to continue. The same can also happen when one partner has dementia when the cognitive decline becomes so severe as to make couple therapy (or individual therapy) impossible. The diagnosis of dementia in itself is no reason not to provide couple therapy, but it is important to keep checking whether the partner with dementia is comprehending sessions and able to recall what was covered in prior sessions. It is important for the person with dementia to recognize the therapist and what the therapist's role is but being able to remember the therapist's name is not essential.

Although it is generally preferable to have older couples come to the therapist's office for the sessions, some older adults with chronic illnesses or disabilities are unable do so. Home visits are important to providing therapy for such couples, who often are among those with highest levels of need. The therapist needs to educate clients in home visits about the structure of the therapy session and maintain a therapeutic stance rather than a "friendly visitor" role. It is also important to ask clients to minimize interruptions as much as possible and to be alert to possible confidentiality issues. Teletherapy is also a potential option for older couples not able to come into the office. Relatively little is known about its use with older adults in general or with older couples. Many older adults are quite comfortable with videoconferencing to maintain contact with family and friends (also see Chapter 30, "Telehealth and Digital Couple Interventions," in this volume, by Doss, Knopp, Wrape, & Morland). If the couple resides in a nursing home, it can be difficult to find a private space, and sessions may well be briefly interrupted at times by staff. There are limits to confidentiality in many care settings, in that other residents are always watching who comes and goes. Discussing with clients how they will handle questions about the therapist visits can be helpful for them.

The Role of the Therapist

Therapists, and especially younger therapists, can find being across the room from much older clients quite daunting. This experience compels us to think through what skills we bring to the work of couple therapy. Focusing on our skills in couple therapy and our knowledge about common issues between partners and how to improve relationships both highlights our strengths and keeps us from relying on personal experience as a source of expertise.

Therapists also need to be alert to their own unintentional ageism, often arising as a sense of helplessness when faced with older clients. The notion that older people cannot be helped by psychotherapy, including couple therapy, is fairly common. A good self-test is to ask what you would do if the clients were younger, then think about why you would not go ahead and do that work with this couple. As described earlier in the section on core understandings, there may be reasons to make some adaptations, but the reasons are seldom age-related as such, but likely due to the social context of the couple or to specific challenges they face.

Therapists also at times react to the length of older couples' relationships, with the assumption that they want to stay together. As with younger couples, some older couples may come to the conclusion that their problems really are not workable and that it is time, possibly well past time, for them to separate. Therapists need to be alert to unrecognized ageism, and possibly to countertransference issues, if they respond to indications that an older couple is headed in this direction with a sense that this relationship must be saved. While we may always hope that our clients' relationships will improve, *needing* them to improve is a different matter.

Most roles of the couple therapist are similar to those with younger couples. One potential exception is that with the pervasiveness of societal ageism and its stereotypes, couple therapists may well find themselves in the position of educating clients about the nature of later life, even when the therapist is younger than the clients. This involves educating clients about aspects of their lives that may be influenced by cohort differences, the social context of their lives as older people in their community, and their responses to the challenges of later life. These attributions are more specific in focus and less irreversible than growing older.

Assessment and Treatment Planning

Understanding the history of the current couple relationship and each partner's previous relationship history is important background for understanding their relationship. Given their ages, there is likely to be too much history to go into in detail, but understanding how many prior serious relationships, how long they lasted, why they ended, and whether one or both partners see connections between the current relationship issues and their pasts is important background. There is then a strategic decision to be made, likely influenced both by how the couple frames their current issues and by the therapist's theoretical orientation, as to how much to explore relationship history versus to focus on the current presenting problem.

If going into the history, from a clinical perspective, it will be the perception of the couple (individually and jointly), of the course of their relationship over time that will count. Wolinsky (1990) urged the importance of the "marital life review" as a part of couple therapy with older couples. Getting an overview of the ups and downs of the relationship over their time together is valuable for both the therapist and the couple, and often puts current conflicts into a different perspective. Reviewing the beginning of a relationship can often remind a couple in distress of why they got together and the early period of relatively good times together. The review may also remind them that they recognized the now problematic aspects of their partner's personality when they decided to become a couple.

When going through a relationship life review, once the beginning of the relationship is covered, exploring the effects of having children (if any) and the experience of raising small children is a next step. Discussing their experience with their adolescent children is often distinct. Launching children into adulthood (or having the adult children continue to live with them or having them return) are further stages in the life review. Understanding connections with the families the adult children have formed and connections to grandchildren and great-grandchildren are further stages that can help both the therapist and partners understand the strengths and challenges of their current relationship.

Some understanding of older adults' generational cohorts and being able to show familiarity with some of their generation's history and likely influences on their values and the course of their relationship can be quite helpful in building rapport. To get a preliminary sense of likely cohort experience, add 20 years to each client's birth year to estimate when they became young adults, and so when they likely acquired a sense of generational identity and associated values. Note whether they are from roughly the same cohort or are enough apart in age to have had different identities. Even a single decade may be enough to make a difference in the sociohistorical influences. Be alert to culture and cohort interactions. Black Americans coming of age in the 1960s are likely to have more focus on the civil rights movement and the changes that it brought than White Americans. For people whose lives started in other nations, the cohort influences will differ and sometimes are quite dramatic. Globalization has transformed the circumstances and the traditional values of many countries around the world in ways that have had dramatic impact on older couples and on their relationships with their children. Much of what the therapist needs to know will, of course, be the specific experiences of this particular couple against those backdrops.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

There is some evidence that preventive psychoeducation with older couples can have positive outcomes (e.g., Trudel et al., 2008); however, evidence for the effectiveness of couple therapy is quite sparse because the work has not yet been done (Ayalon & Koren, 2015; Lambert-Shute & Fruhauf, 2011). There is extensive evidence that individual psychological therapies work well with older adults (e.g., Scogin & Shah, 2012), and no evidence that individual therapies that are effective with younger adults fail with older ones. So there is reason to be optimistic about transferring experience with younger couples to older couples once core understandings of older couples are integrated into clinical conceptualization and interventions.

The primary contraindications for couple therapy with older couples that would differ from those for younger couples are related to severe levels of disability and especially to more advanced levels of dementia. There are no clear-cut rules for when couple therapy would no longer be appropriate. Most of the dementias of later life are slowly progressive and deciding when the capacity to benefit from therapy is no longer there is difficult and cannot be based on cognitive screening scores alone. Certainly, once the client has trouble recalling the gist of previous sessions or is unable to participate in the current session, it is time to stop.

CONCLUDING COMMENTS

CALTAP provides a framework for thinking about ways in which therapy with older couples may need some adaptation from work with younger couples. With normal, healthy aging, one may expect that the couple will enter therapy with the wisdom of accumulated adult life experience and with considerable experience of relationships. This is especially true for couples married for several decades, but it can also be true for older couples who are more recently partnered to one another but have prior experience of being coupled with others. Much of what is different in work with older couples is due to cohort differences and to differences in the social context in which older couples may find themselves rather than due to developmental aging or even to the development of the relationship over time. Additional sources of need for particular knowledge and skills come from specific challenges of later life including chronic illness, disability, caregiving, and grief. The CALTAP model also calls attention to the potential role of cohort or generational differences in making therapy with older couples different from work with younger couples, but there is little literature or evidence to guide thinking about cohort-based adaptations.

In the context of individual therapy, I have urged the view that the primary impact of these sources of change in working with older adults is likely to be on the presenting problem and on the relationship with the therapist (e.g., Knight, 2004; Knight & Pachana, 2015), with little to no need to alter the underlying models or specific techniques of therapy. Although much more needs to be done to explore the nature and the efficacy of therapy with older couples, this assertion also is applicable to couple therapy. Much of the difference in working with older couples is likely to be related to the impact of social context and the challenges of later life on presenting problems of older couples on the one hand, or on the therapist's reaction to working with older couples on the other.

SUGGESTIONS FOR FURTHER STUDY

Hillman, J. (2012). *Sexuality and aging: Clinical perspectives*. New York: Springer.

Knight, B. G. (2004). *Psychotherapy with older adults* (3rd ed.). Thousand Oaks, CA: SAGE.

Knight, B. G., & Pachana, N. A. (2015). *Psychological assessment and therapy with older adults*. Oxford, UK: Oxford University Press.

Lichtenberg, P. A., & Mast, B. T. (Eds.). *APA handbook of clinical geropsychology (*Vols. 1 and 2). Washington, DC: American Psychological Association.

Qualls, S. H., & Williams, A. A. (2013). *Caregiver family therapy: Empowering families to meet the challenges of aging*. Washington DC: American Psychological Association.

Scogin, F., & Shah, A. (2012). *Making evidenced-based psychological treatments work with older adults*. Washington, DC: American Psychological Association.

REFERENCES

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Ayalon, L., & Koren, C. (2015). Marriage, second couplehood, divorce, and singlehood in old age. In P. A. Lichtenberg & B. T. Mast (Eds.), *APA handbook of clinical geropsychology: Vol. 2. Assessment, treatment, and issue of later life.* (pp. 617–644). Washington, DC: American Psychological Association.

Baucom, D. H., Porter, L. S., Kirby, J. S., & Hudepohl, J. (2012). Couple-based interventions for medical problems. *Behavior Therapy, 43,* 61–76.

Butler, R. N. (1975). *Why survive?: Being old in America.* New York: Harper & Row.

Carr, D., & Utz, R. (2020). Families in later life: A decade in review. *Journal of Marriage and Family, 82,* 346–363.

Carstensen, L. L., Gottman, J. M., & Levenson, R. W. (1995). Emotional behaviour in long term marriage. *Psychology and Aging, 10,* 140–149.

Carstensen, L. L., Graff, J., Levenson, R. W., & Gottman, J. M. (1996). Affect in intimate relationships: The developmental course of marriage. In C. Magai & S. H. McFadden (Eds.), *Handbook of emotion, adult development, and aging* (pp. 227–247). San Diego, CA: Academic Press.

Goldsen, J., Bryan, A. E. B., Kim, H., Muraco, A., Jen, S., & Fredriksen-Goldsen, K. I. (2017). Who says I do: The changing context of marriage, health and quality of life for LGBT older adults. *Gerontologist, 57,* S50–S62.

Hillman, J. (2012). *Sexuality and aging: Clinical perspectives.* New York: Springer.

Knight, B. (1996). Psychodynamic therapy with older adults: Lessons from scientific gerontology. In R. Woods (Ed.), *Handbook of clinical psychology and ageing.* London: Wiley.

Knight, B. G. (2004). *Psychotherapy with older adults* (3rd ed.). Thousand Oaks, CA: SAGE.

Knight, B. G., & Lee, L.O. (2008). Contextual adult life span theory for adapting psychotherapy. In K. Laidlaw & B. G. Knight (Eds.), *Handbook of emotional disorders in late life: Assessment and treatment* (pp. 59–88). Oxford, UK: Oxford University Press.

Knight, B. G., & McCallum, T. J. (1998). Family therapy with older clients: The contextual, cohort-based, maturity/specific challenge model. In I. H. Nordhus, G. VandenBos, S. Berg, & P. Fromholt (Eds.), *Clinical geropsychology* (pp. 313–328). Washington, DC: American Psychological Association.

Knight, B. G., & Pachana, N.A. (2015). *Psychological assessment and therapy with older adults.* Oxford, UK: Oxford University Press.

Knight, B. G., & Poon, C. (2008). The socio-cultural context in understanding older adults: Contextual adult life span theory for adapting psychotherapy. In R. Woods & L. Clare (Eds.), *The handbook of the clinical psychology of ageing* (2nd ed., pp. 439–456). Chichester UK: Wiley.

Knight, B. G., & Satre, D. D. (1999). Cognitive behavioral psychotherapy with older adults. *Clinical Psychology: Science and Practice, 6,* 188–203.

Lambert-Shute, J., & Fruhauf, C.A. (2011). Aging issues: Unanswered questions in marital and family therapy literature. *Journal of Marital and Family Therapy, 37,* 27–36.

Levenson, R. W., Carstensen, L. L., & Gottman, J. M. (1994). The influence of age and gender on affect, psychophysiology, and their interrelations: A study of long-term marriages. *Journal of Personality and Social Psychology, 67,* 56–68.

Muruthi, B., McCoy, M., Chou, J., & Farnham, A. (2018). Sexual scripts and narrative therapy with older couples. *American Journal of Family Therapy, 46,* 81–95.

Qualls, S. H., & Williams, A. A. (2013). *Caregiver family therapy: Empowering families to meet the challenges of aging.* Washington, DC: American Psychological Association.

Raley, R. K., & Sweeney, M. M. (2020). Divorce, repartnering, and stepfamilies: A decade in review. *Journal of Marriage and Family, 82,* 81–99.

Rosowsky, E. (1999). Couple therapy with long-married older adults. In M. Duffy (Ed.), *Handbook of counseling and psychotherapy with older adults* (pp. 242–266). New York: Wiley.

Schoen, R., & Canudas-Romo, V. (2005). Timing effects on first marriage: Twentieth-century experience in England and Wales and the USA. *Population Studies, 59,* 135–146.

Scogin, F., & Shah, A. (2012). *Making evidenced-based psychological treatments work with older adults.* Washington, DC: American Psychological Association.

Shaw, J. (2012). Approaching your highest sexual functioning in relationship: A reward of age and maturity. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (2nd ed., pp. 175–194). New York: Taylor & Francis.

Sterns, H. L., & McQuown, C. K. (2015). Retirement redefined. In P. A. Lichtenberg & B. T. Mast (Eds.), *APA handbook of clinical geropsychology: Vol. 2. Assessment, treatment, and issue of later life* (pp. 601–616). Washington, DC: American Psychological Association.

Stroebe, M. S., & Schut, H. A. W. (1999). The dual process model of coping with bereavement: Overview and update. *Death Studies, 23,* 197–224.

Syme, M. L., Cordes, C. C., Cameron, R. P., & Mona, L. R. (2015). Sexual health and well-being in the context of aging. In P. A. Lichtenberg & B. T. Mast (Eds.), *APA handbook of clinical geropsychology: Vol. 2. Assessment, treatment, and issue of later life* (pp. 395–412). Washington, DC: American Psychological Association.

Trudel, G., Boyer, R., Villeneuve, V., Anderson, A., Pilon, G., & Bounader, J. (2008). The Marital Life and Aging Well program: Effects of a group preventive intervention on the marital and sexual functioning of retired couples. *Sexual and Relationship Therapy, 23,* 5–23.

White, L., & Edwards, J. N. (1990). Emptying the nest and parental well-being: An analysis of national panel data. *American Sociological Review, 55,* 235–242.

Willert, A., & Semans, S. (2000). Knowledge and attitudes about later life sexuality: What clinicians need to know about helping the elderly. *Contemporary Family Therapy, 22,* 415–435.

Wolinsky, M. A. (1990). *A heart of wisdom: Marital counseling with older and elderly couples.* New York: Brunner/Mazel.

Wollert, R. W., Knight, B. G., & Levy, L. H. (1980). MTC: A collaborative model for professionals and self-help groups. *Professional Psychology, 11,* 130–138.

CHAPTER 21

Divorce Issues in Couple Therapy

Jay L. Lebow

BACKGROUND

Couple therapy is usually thought of as simply directed toward couples improving in their relationship processes and their relationship satisfaction. Indeed, this book is filled with great examples of a wide array of ways of doing that. Yet couple therapy also often occurs in the context of a much different presenting situation, where separation and divorce are possible outcomes and couples enter on the cliff of moving to one of those outcomes. Many clients enter couple therapy for the explicit purpose of utilizing this venue as a step in the process of leaving their partner, what is now for some an obligatory step that supplants what in earlier times might have been a visit with clergy or older family members. Others during couple therapy reach the conclusion that divorce is the best option, based in part on their lack of success in improving their relationship satisfaction or target complaint during treatment.

How, then, does the couple therapist deal with the slippery and controversial slope of this possible outcome, and what can a therapist do to help those who want to separate or divorce do so successfully? This chapter has two purposes: (1) to examine the ways couple therapists can best deal with discussion of divorce during couple therapy and the place of divorce as a possible outcome of therapy and (2) to look at the ways couple therapists can best help those who have decided to divorce.

At the onset, a few words about vocabulary. The words "couple" and "marital" in this chapter are presented interchangeably, referring to participation in committed relationships, regardless of legal status; the term "divorce" is used to refer to the ending of such committed relationships, whether or not those relationships have legal status. However, the legal aspects of divorce and their impact are unique to marriages recognized by the state, and aspects of the interface with the judicial system differ considerably for relationships that do not have legal status about such matters as finances and shared parenting. Adding additional complexity to speaking to divorce is the increasing age of marriage in most of the developed world, which leaves many highly involved couples unmarried but experiencing relationship dissolution much like that in divorcing couples, as well as legal impediments to marriage for some couples, such as lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples in various places.

Therapy specifically focused on divorce has a surprisingly small professional literature. Most of that discussion focuses on utilizing various forms of couple therapy to improve relationship satisfaction and avoid divorce. The most prominent writings related to therapy in the context of divorce elaborate differences between successful and more difficult divorces (Ahrons, 1994; Emery, 2012; Emery & Dinescu, 2016), patterns that place children at risk in high-conflict divorce (Johnston & Roseby, 1997), therapy in relation to family disputes in Court (Drozd, Saini, & Olesen, 2016), and discernment for deciding on whether to work on marriages or divorce (Doherty & Harris, 2017). Elsewhere, I present a specific integrative treatment for high-conflict divorce tailored to the special life situations of these families (Lebow, 2019).

CORE UNDERSTANDINGS ABOUT DIVORCE

Divorce is a highly controversial topic. Before discussing how the interface with societal values does, can, or should impact treatment, I begin with a brief review of research about divorce, which mostly is unambiguous. What does the now-large body of excellent research about divorce tell us (Sbarra, Bourassa, & Manvelian, 2019)?

Approximately 40 to 50% of marriages in the United States end in divorce (Amato, 2010; Cherlin, 2010). Across almost all countries, divorce rates have increased from 1960s to the present. While divorce rates have leveled off after rising sharply in the late 20th century, divorce rates understate rates of relationship dissolution because in most Western countries couple cohabitation is now a common form of committed partnership. Furthermore, divorce in some populations, such as older adults, continues to rise.

For almost everyone experiencing divorce, there are short-term negative consequences (Auersperg, Vlasak, Ponocny, & Barth, 2019; Raley & Sweeney, 2020). Both children and adults show more role strain, a greater number of behavioral problems, and, to use Hetherington's suggestive words, a feeling of not "being me" (Hetherington & Kelly, 2002). However, after an initial period of 1–2 years, most family members in divorcing families do well and cannot be distinguished from those in families that did not go through divorce on measures of functioning, symptoms, or happiness (Hetherington & Kelly, 2002). Rates of problems in family members who have experienced divorce remain higher than in those who have not, but only marginally higher (Amato & Booth, 2002; Auersperg et al., 2019; Hetherington, 1999; Hetherington & Kelly, 2002; Raley & Sweeney, 2020). The majority of children whose parents divorce fall within the normal range on all measures of functioning and symptoms.

It is crucial in considering these data to highlight that when research involves comparisons of families that experience divorce and those that do not, the comparison (nondivorced) group comprises families with both happy and unhappy marriages. Thus, even the small differences in the rates of difficulties in families experiencing divorce and in those who do not may be inflated because the comparison being made is not a full comparison with people who experience relationship distress. Said another way, it is hard to sort out how much of what effects there are stems from divorce and how much stems from simply having relationship difficulties. There is no specific evidence that family members who go through divorce over the long term do any worse than those in families in which the marriage is unhappy but the parents remain together (Greene, Anderson, Hetherington, Forgatch, & DeGarmo, 2003).

High conflict in marriage is a major risk factor both for children in families with marriages that last over time and those with marriages ending in divorce (Buehler, 2020; Harold & Sellers, 2018). It is not clear whether high conflict is more deleterious in nuclear or in divorced families. However, it is clear that in both contexts, high conflict is quite damaging for most everyone.

Other factors have an enormous impact on which children and adults do well or do poorly when divorce occurs. For example, adding too many other life changes (e.g., moving several times, change in financial status, and parental remarriage within a short span) to the change involved in parents divorcing vastly increases children's risk (Hadfield, Amos, Ungar, Gosselin, & Ganong, 2018; Hetherington, 1999). Financial strain is especially prevalent in mothers and can have pervasive effects on them and their children (Raley & Sweeney, 2020). The emergence of parental psychopathology in the wake of divorce and low levels of child monitoring also increase children's level of vulnerability.

Research also shows that although the presence of massive deleterious effects of divorce on functioning is easily overstated, the emotional pain in the experience ranks among the most significant life stressors. Children and adults almost universally describe challenging affective experiences about which they often have continuing feelings. When Emery (2004) surveyed college students at the University of Virginia about their experiences with divorce, he found that even among these high-achieving young people whose life functioning would be generally regarded as highly successful, stories of family life were filled with pain. Nearly 50% believed they had had a harder childhood than others (compared to 14% among those whose parents' marriage remained intact), and 28% wondered whether their fathers loved them (compared to 10% among those whose parents' marriage remained intact).

Amato and Afifi (2006) have identified a group of children who do worse when their parents divorce rather than remain together: children in families where parents' unhappiness is not transparent to their children. They find that the sense of loss for these children is particularly great, causing them to be especially vulnerable. However, others challenge this view of these children, arguing that one does not in fact know how their lives would have progressed if their parents had not divorced.

Protracted conflict over child custody and visitation is especially deleterious for all involved (Emery & Dinescu, 2016; Johnston, Walters, & Olesen, 2005; Kelly, 2003b). High levels of parental conflict almost always accompany disputes over child custody and visitation (Johnston & Campbell, 1988). The child-centered conflicts engendered are particularly upsetting for children (Buchanan, Maccoby, & Dornbusch, 1996; Johnston & Roseby, 1997).

Divorce is frequently also a very different event for the two partners. Often, one partner is far more motivated to seek divorce and has been contemplating divorce for a longer period. Although stresses of divorce remain, almost inevitably, this partner more readily constructs a more positive narrative about the divorce than the partner who feels acted upon.

In summary, divorce is painful, but it represents a life challenge rather than an invariable pathway to difficulty. Most adults and children recover after a period, even though most retain painful memories of that time. The data are ambiguous as to whether divorce is better or worse for adults and children than continuing to live in a family in which unhappily married parents stay together, though indications are that the answer to this question has much to do with the nature of those family lives—that is, whether life is overtly smooth or filled with conflict, anxiety, violence, or depression.

The research also suggests that divorce represents not so much a single event as a developmental process. Families undergo several challenges and transitions in the process of adaptation to divorce. The first phase, typically lasting 1–2 years after divorce, is a period of high stress and turmoil. Because most families are more distressed after 1 year than immediately after the divorce, many families come to feel overwhelmed and discouraged at that time. However, longitudinal research (Hetherington, 1999) indicates a remarkable recovery for most families by the end of the second year. Most families stabilize in 2 years, and most parents and children are functioning well when followed up 6 years later. Still, many families undergo multiple transitions as residences and custody arrangements change over time. When remarriage of one or both partners occurs, other complexities are introduced—some that promote better coping and others that involve further challenges. Nearly two-thirds of women and three-fourths of men remarry after divorce (Weitzman et al., 1992) (most of this gender difference today occurs in those over 55 years old). In most families, divorce and remarriage merge into a continuous process (also see Papernow, Chapter 22, in this volume, on stepfamily couples).

Added to these complexities is the ambiguity of norms regarding the degree of involvement between former spouses, between parents and children, and with new partners/stepparents during and after divorce (Ahrons, 2004). Divorce, like other major life transitions, disrupts a family's "paradigm"—the worldview and basic premises that underlie family identity and guide its actions. When individuals share unrealistic expectations that a postdivorce family should function like a nondivorced two-parent family, there is a sense of disappointment and deficiency when these fantasies cannot be met (Papernow, 2018). Yet there are few fixed anchors for expectations. We live in a changing world in which norms for aspects of divorce such as the division of children's time with parents have radically evolved in recent years, and most of us know of a divorced couple that still shares Thanksgiving together.

Research and clinical experience also suggest there are better and worse ways of divorcing. The divorce process typically goes best when there are opportunities for divorcing partners to communicate; when there is a sense of having a chance to work through the problems; when extramarital involvements and marital violence are not part of the picture; when children are not triangulated into the parental conflicts; and when there is an orderly process of making decisions relevant to the divorce. The interface with the judicial system makes a difference as well. Situations in which lawyers act in aggressive ways and partners are pushed to reside together for unusually long amounts of time after a decision to divorce often lead to the degeneration of the process and poor outcomes.

Culture is also a major factor in how divorce is experienced. Over the last two centuries, divorce has moved from being unacceptable in almost all cultures to being seen as one of many life choices in much of the world. Still, many cultures and subcultures still regard divorce as a violation of norms. Families that include members anchored in different cultural meanings of divorce easily become lost in mutual misunderstanding.

Families that do divorce must engage in a decision process about dividing assets and, when there are children, about creating an arrangement for decision making after divorce (termed "joint" or "sole" custody) and about the extent to which children should reside with each parent. This process always is fraught with some difficulty but can range from merely anxious and sad to endlessly painful and mired in legal and person disputes. There is an emerging literature that show joint custody and some significant level of shared parenting time is associated with better short- and long-term outcomes (Baude, Pearson, & Drapeau, 2016; Steinbach, 2019), though what works best is often idiosyncratic to the specific family (Lebow, 2019). Those marriages and families that remain endlessly in protracted conflict about these issues are very much at risk for myriad difficulties.

THE PRACTICE OF WORKING WITH DIVORCE IN COUPLE THERAPY

The Decision to Divorce as an Aspect of Couple Therapy

Probably no issue in couple therapy is as contentious as how to handle the decision to divorce. In couples that enter couple therapy, often at least one person is seriously considering the costs and benefits of divorce as a possible course. Moreover, divorce represents a special and complex outcome in couple therapy. Although divorce might be taken as obvious evidence of the failure of couple treatment to improve couple satisfaction, it also can represent a constructive choice through which one or both partners emerge as happier and improved in their individual functioning. Couple self-reports about this outcome are in most cases divided, with one partner regarding this transition as necessary and helpful, and the other seeing it as a negative outcome.

The prescribed strategies for intervention in the wake of one or both partners' indicating a desire to divorce vary across couple therapists, yet there is a great deal of shared common ground. Most couple therapists strongly support marriage; therefore, they listen carefully to the basis for the decision to divorce and almost invariably explore whether there remains any possibility for reconciliation. Good couple therapists also take the wish to divorce on the part of one or both partners seriously, and they work to establish an empathic connection and therapeutic alliance with both parties in the process of working with this issue.

Nonetheless, there remains a divide between couple therapists about the strength of these messages in the wake of the presentation of a desire to divorce. At one extreme are the self-designated marriage savers and "divorce busters" (Weiner-Davis, 1992), who suggest that the therapist should strongly side against a decision to divorce or separate. Doherty (2001) offers a somewhat more tempered version of this position, suggesting that therapists begin with a strong family-centered declaration on the side of marital stability, followed by a focus on reviving the marriage, supporting divorce only if all possible efforts to produce a viable marriage are exhausted. At the other extreme are the writers of popular books such as *Creative Divorce* (Krantzler & Krantzler, 1999) and *Conscious Uncoupling* (Thomas, 2015), who support divorce as a growth-enhancing outcome. Ahrons (1994, 2004) suggests a moderate version of this position, pointing to the differences between those who divorce well and those who do so poorly, and the reality that some marriages either never worked or lost their viability long ago. Many writers also distinguish between marriages in which divorce occurs early in a childless marriage and those in which divorce occurs later; these authors take a more conservative approach to this potential change when there are children still at home (Amato & Booth, 2002).

Those strongly identified with marriage preservation view therapists and, for that matter, Western society as too easily condoning decisions to divorce, whereas those at the opposite pole accentuate the normality of divorce as a life decision in the 21st century. Between these poles lie most couple therapists, who strongly support marriage yet also see divorce as an acceptable option.

There are a few situations for which the specifics of individual circumstances transcend ideology and for which there is greater consensus about how to proceed. For example, it is widely regarded that severe intimate partner violence is a circumstance under which divorce is strongly preferable to remaining married, when the total well-being of all parties is considered.

Yet in the majority of situations in which one or both partners consider divorce, the shadow of the therapist's personal values is very powerful about questions such as how much effort to put into a relationship in which there are issues that cannot be fully resolved. It would be inappropriate to suggest that there are correct or incorrect positions relative to such personal values. These are positions that can be endlessly argued. There is consensus among most couple therapists regarding a "both–and" position, which supports marriage but also remains open to consideration of the life stories and feelings of the partners in treatment when divorce looms as an option. There also is consensus that the first task is to assess the viability of the relationship, most especially in terms of each partner's present commitment. Part of the couple therapist's skill lies in distinguishing deeply held convictions that divorce represents the best option from transient expressions of emotion or tactics in communication that include raising the specter of divorce. Some relationships clearly are highly likely to remain mired in problems, regardless of intervention. When the sorts of relationship patterns that have been identified indicate the complete erosion of intimate connection, with low levels of positive connection coupled with contempt or stonewalling (Gottman, 1999), serious questions surround the viability of a marriage. Furthermore, when one partner unequivocally states that they are leaving the marriage, there is little to be gained from anything other than exploring how absolute this feeling is and observing whether that state lasts over time, and then, if this remains the reality, helping the couple and family cope as well as possible with divorcing.

Doherty and Harris (2017) have developed a widely disseminated model for specifically dealing with couples in which one partner is moving toward divorce while the other partner wants to preserve the marriage. They distinguish the work that they term "discernment counseling" from couple therapy. Discernment counseling focuses on helping each partner discern whether, given the present circumstances of moving in different directions (termed "leaning in" and "leaning out"), they can collaborate in couple therapy to work at the underlying difficulties or in separation and divorcing. An important contribution of this work has been to distinguish discernment (evaluating whether one wants to work on the marriage) from the primary activity of couple therapy (working to improve the relationship). Too often, couples in "couple therapy" are constrained in their work together because of the dance occurring around one party leaning out and thereby not being committed to the work on the marriage. Doherty and Harris provide a specific format for this work, which largely comprises individual sessions with each partner with the same therapist, in which each member of the couple sorts out whether they can truly commit and engage in couple therapy. Doherty and Harris developed discernment therapy primarily to respond to the striking percentage of partners who even in the last stages of divorce identify themselves as ambivalent or against this decision. Although the original intent for discernment therapy is grounded as a last chance for marriage preservation, this method can also represent a process during which the "leaning in" partner might, with the help of the therapist, learn to cope with the inevitability of divorce.

Separation represents a very special place between marriage and divorce. Separation can allow for a cooling-off period to process couple difficulties in therapy and allow partners to evaluate difficult-to-assess factors such as their underlying attachment. Separation appears most useful when partners have highly charged relationships and when there remains positive connection even in the presence of the wish to separate. The disadvantages of separation are that most separating couples ultimately divorce, and that what may be taken by one party as a time of continuing to work on the marriage may be for another one of the famous "50 ways to leave your lover." Separation is only helpful to the extent that couples set clear ground rules for the experience (with ground rules about matters such as dating, time together, time with children, and shared decision making), process their difficulties, and work on rebuilding their relationships during this time apart. Historically, there have been a few approaches that proactively prescribe structured separation with clear ground rules for distressed couples who contemplate divorce (Raffel, 1999), but such approaches are encountered less frequently today.

Assessing the Inclination to Divorce

One task in couple therapy lies in assessing how close each partner is to divorcing. Typically, client self-reports and reports about partner actions provide a clear indication of how close the parties are to divorcing. Yet it is important to understand that such statements need to be understood in context; such declarations or threats often represent efforts to exert influence or experience catharsis in people who are far from taking action. Actions that signal the process of disengagement, such as separating, engaging new partners, having serious discussions with divorce attorneys, filing for divorce, or separating finances, provide what may be more telling unobtrusive measures of the inclination to divorce. So, too, may the frequent presence of those behaviors that, as Gottman (1999) has shown, predict divorce, such as contempt, belligerence, and stonewalling. For those wishing to utilize a self-report instrument to assess readiness to divorce, Weiss and Cerreto (1980) have developed the Marital Status Inventory, a very brief and user-friendly instrument, which assesses the presence of thoughts and behaviors related to divorcing.

The assessment of the inclination to divorce is, of course, only part of the assessment of a couple. As part of that assessment, it is helpful to place couples in a two-by-two matrix of the inclination to divorce by relationship quality. In such a matrix, those who fall in the cell "high divorce readiness/high relationship quality" seem to be candidates for special efforts to preserve these marriages, particularly in situations where there are minor children. Always bear in mind that there are couples with tragically low levels of relationship satisfaction, and high levels of commitment, who never divorce; that is, for whom divorce is not an option.

Working with Partners Who Have Decided to Divorce

Many couples seek therapy to deal explicitly with the process of divorcing; other therapies morph into divorce therapy when one or both partners decide to leave the relationship. Explicit work toward a good divorce is an underappreciated variation of couple therapy. The differences between couples that divorce well and those that do not are pronounced, and effects radiate through children and extended family members. High-conflict divorce is particularly toxic for all (Sbarra et al., 2019). There are numerous other high-risk scenarios, such as when children are triangulated into parental conflict, when a marriage ends with little communication and much unfinished business, or when problems in the marriage have never been acknowledged. Complicating matters, this marks a time during which partners are typically in the precontemplation stage of change in recognizing any of their own problematic relational behaviors, instead accentuating the difficulties in each other. Indeed, it is a time during which self-protective emotions, thoughts, and behaviors that create distance from the partner and can demonize the other often flourish. This is an experience for which few people are prepared, and a transition in which intervention can make a significant difference.

There are three major methods for intervention with divorcing couples: group psychoeducational prevention programs, mediation, and divorce therapy. Prevention programs teach about the process of divorce, providing guidelines about what to expect and how best to deal with the feelings and problems that typically arise (Schramm & Becher, 2020). Such programs sometimes also involve the sharing of personal experiences. Several different brief programs targeting adults, fathers, mothers, children, or families experiencing divorce that have been demonstrated to have a positive impact on the divorce process and to mitigate potential problems in areas such as coparenting and emerging adult and child difficulties (Pedro-Carroll, 2005; Pruett et al. 2016; Schramm & Becher, 2002), are offered as extensions of the court in many jurisdictions.

Mediation involves a formal process of partners' negotiating differences about legal issues involved in divorce, such as the division of assets, child support, child custody, and time with each parent. The typical process involves meetings with each partner and the partners together to define the issues, followed by negotiation sessions that typically are 2 hours in length (daylong meetings are an alternative format). Mediators do not have the power to make decisions but endeavor to promote a positive exchange in the process of resolving differences. Mediators do at times provide feedback to the parties about typical arrangements, that is, ones that work well and ones that work poorly, and the likelihood that a court will support one position over another if there remains a dispute. The success of mediation in promoting positive outcomes in divorce for both parents and children has been well established (Emery, 1999; Emery, Sbarra, & Grover, 2005; Kelly, 2004). As an offshoot of mediation, a new profession called "parent coordinator" has also emerged. Parent coordinators can arbitrate (i.e., make decisions about) issues involving children when mediation fails, thus avoiding court appearances in relation to minor disputes among those for whom the major issues have been decided (Kelly, 2003a). Thus far, there is no evidence on the impact of parent coordination, though clinical experience has been favorable.

Divorce therapy differs from prevention and mediation, in that therapists can engage in the full range of typical intervention strategies available in psychotherapies. The remainder of this chapter examines divorce therapy. The reader is referred to Pruett and colleagues (2016) and Pedro-Carroll (2005) for consideration of psychoeducational programs, and to the work of Emery (1999) and Kelly (2004) for discussions of mediation. Below I review core intervention strategies most relevant to the treatment of both high- and low-conflict divorcing families.

There are various ways of doing therapy with divorcing couples, informed by the methods of couple therapy described in this book. However, all divorce therapy is necessarily integrative (Lebow, 2019) given the many quite distinct tasks involved that are intrinsic to this territory—ranging from establishing new boundaries to improving communication to working with deep affect. There is no single, "right" way of approaching clients; rather, there are ways that are more and less likely to be effective given this set of clients, this problem, and this therapist.

What follows is a generic list of useful strategies from which therapists can draw and adapt to specific cases in working with divorcing couples. For most of these operations, variations for high- and low-conflict divorce are explicated.

Goal Setting

In dealing with possible or probable divorce, goal setting is one of the most essential aspects of treatment. It is common for partners entering therapy to have disparate goals (e.g., working together to support the children about the divorce vs. working on the marriage). This is often the case even when there has been verbal agreement before therapy about a pathway. And even if both partners agree about the decision to divorce, it is rare for both to share the same vision about where therapy can best focus, with each often having a vision of individual change in the partner as most important. The working on a composite set of goals so helpful in much of conjoint therapy typically reaches an intrinsic limit here. Moving toward separating lives and being together are typically incompatible, and some synthesis of individual goals is needed.

When one partner wants a divorce and the other does not, the first phase of treatment focuses on finding a collaborative focus. Almost invariably, the initial exploration centers on whether the partner who is more ready to divorce will agree to work on the marriage for a time. As an offshoot of this exchange, a compromise sometimes is reached to explore whether feelings can change over a brief period, and if they do not change, to proceed with divorce. As already noted, Doherty and Harris (2017) have recently developed a pre–couple therapy method called discernment counseling in which the principal task is to enable collaboration about whether repairing the marriage or divorcing will become the goal of the subsequent therapy. Those couples who enter therapy when there is ambivalence on the part of both partners are best segued into or referred to such a process before taking up the work of separating their lives.

Nonetheless, much of the time in couples moving toward divorce, one or both partners enter treatment with a fixed and unmoving plan to divorce. And in numerous other couples, a brief sojourn into exploring possibilities for the marriage in couple therapy or discernment counseling is followed by a decision of one or both partners to divorce. When one or both partners have already psychologically exited the marriage, the most helpful focus shifts to helping partners through this transition.

Negotiation of the content of sessions that follow is much like the negotiation about content in any other couple therapy. Each party lists their concerns, and an agreed-upon agenda is generated. Yet there is a core paradox in this work. Divorcing couples are separating their lives; that is, one task in divorce lies in transmuting whatever core attachment remains in the relationship into something else. Therefore, each aspect of the therapy must be considered against this lens. How do members of a couple share with one another in therapy, yet work toward separating their lives? Couples vary enormously in their ability to engage in these two very different sorts of tasks at the same time. For some, sharing vulnerability with a partner who is felt to have committed a betrayal is the very opposite of therapeutic, while for others it is a useful step in parting.

There are many ways partners divorce, and no ideal, "one-size-fits-all" way that partners handle this process with each other. For some, creating a great deal of distance works best; for others, a sense of resolution following intense processing feels most helpful. Notably, partners may be mismatched in how they best envision this event occurring, adding to relational difficulties.

One frequent initial agenda lies in helping the partner who is less motivated to divorce to accept the present reality given that a decision to divorce does not require agreement between the partners about this decision. Work then can turn to dealing with feelings that accompany this parting and to working out the issues they must deal with as partners.

It is easy to name the most difficult and ultimately pathological variations of pathways to divorce. In the high-conflict variation, the practical matters that need to be resolved in this life transition cannot be negotiated without extreme conflict. Some couples move to complete avoidance because levels of conflict in experiencing one another are so great. In another variation on the same theme, family members and friends are triangulated into the conflict and become active combatants. Johnston and Campbell (1988) aptly referred to these as "kinwars." It is particularly problematic when children are thus triangulated. Others are blocked not so much by conflict as by inner pain. Still other couples end their marriages with much unfinished business that is never processed, and for which there never can be any sense of understanding or resolution about what has occurred.

Divorcing couples with children are in a much different situation than childless couples. When there are no children, the period of partners' dealing with one another is typically delimited once there is a decision to divorce, followed by little contact (couples like those that Ahrons [1994] called "perfect pals," who segue into a postmarital friendship, are a rare exception). In marked contrast, couples with children must engage in some degree of co-parenting (or notable lack thereof) for the rest of their lives. This holds multiple meanings. It potentiates the importance of reaching some resolution given the importance of future co-parenting. It also presents greater opportunities ultimately for not only mutual acceptance and postdivorce connection but also endless conflict. Among those with children, the challenges also differ between those with minor children and those with adult children in the level of executive decision making required, though both groups face challenges. For those with children of any age, some degree of co-parental alliance and agreement about the nature and level of that alliance (e.g., close and connected vs. *laissez-faire* and distant) is much needed.

Whatever the presenting situation, collaborating with couples to set realistic goals for therapy represents a crucial task. For most, this consists of doing enough to allow for a less awful parting and good enough co-parenting relationship when there are children, that is, to stay in the normal range in terms of moving through this transition. For a few, goals are more ambitious: to learn from this experience, to mourn the loss of the relationship, and to deal with whatever other outstanding issues have emerged. Some couples want merely to use treatment to make for a fragile peace, so that divorce can occur with the least conflict possible; others enter with specific goals, such as working with particular high-risk children; still others seek to take a deeper look at their lives and relationships; and others have no personal goals but are mandated by courts to participate. Although most therapists view the work involved in exploring the deeper feelings in conjoint therapy as a better way to leave what was thought to be a lifelong relationship, partners' wishes to keep treatment simple and direct are common and must be taken seriously.

Treatment also typically varies with the ecology of the couple's relationship. As Whitaker highlighted long ago (e.g., Whitaker & Miller, 1969), feelings of emotional connection do not cease just because a relationship ends. Most people can call up feelings toward former partners long after divorcing. In low-conflict situations in which the desire to divorce is mutual, and cooperation remains high and may even involve a positive postdivorce connection, the possibilities are quite different from those in a high-conflict divorce in which minimizing conflict and achieving parallel lives may be the only achievable goals.

The Therapy Contract

The establishment of a clear therapeutic contract is essential in any psychotherapy, but clarity about this contract is even more crucial in the context of impending divorce. Partners may have very different goals, with one thinking of "marriage therapy" to resuscitate a relationship, and the other of "divorce therapy" to end it. Clients also often bring inappropriate frames to this work; one partner (or both) may believe that the therapist will act as a moral judge who will cajole and/or shame the other partner into moving to that client's position, or even act as custody evaluator in mandating changes in the other's behavior. In high-conflict cases, the involvement of attorneys and the court in almost all aspects of clients' lives brings additional importance to a clear, agreed-upon contract.

Confidentiality is an expectation in this therapy, as in other mental health treatment. However, special constraints on confidentiality should clearly be recognized. Because clients are in a life crisis, partners often discuss therapy sessions with friends and adult family members, and frequently no rule or agreement can constrain this. In divorces in which a dispute over some aspect of child custody is at issue that involve the Court, it is a general expectation that some reporting about the therapy will be shared with child custody evaluators and the attorney for the children when these roles are filled with the signing of appropriate releases (Gould, 1998; Greenberg & Gould, 2001). Such exceptions to confidentiality should be clearly elaborated. There also are times when the leverage of informing the court is essential to maintaining both parties' participation and cooperation in the treatment (Lebow, 2019). Whatever the eventual contract becomes in terms of participants and confidentiality, these parameters should be clearly stated and approved with a signed consent form at the beginning of therapy (also see Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen).

The Therapeutic Alliance

Establishing a working alliance with each partner is an essential aspect in divorce therapy but establishing such an alliance is difficult. Partners typically lack what Pinsof and colleagues (2018) call a "within-system" alliance with each other, making a working alliance between clients and therapist much more difficult. The principal ingredients of a successful alliance in most cases lie in the therapist's conveying a nonjudgmental connection with each partner, creating a holding environment that allows a sense of safety in which to share thoughts and feelings, and intervening as necessary to protect therapy sessions from becoming pathogenic. Given the frequently present stories of victim and victimizer, of behavior viewed in radically different ways by the partners, and of questionable behavior on the part of at least one party (e.g., extramarital involvements or triangulation of children into marital disputes), alliance ruptures can frequently occur. Therefore, the repair of such ruptures becomes essential in almost all divorce therapy. Such repair is not magic but extends from establishing a general sense of fairness and understanding, coupled with explanation and working through the issues that resulted in the rupture.

Witnessing

Empathically listening to what are often stories of enormous difficulty and pain is an essential ingredient of effective divorce therapy. The therapist's difficult task is to balance hearing these stories and maintaining a multipartial alliance that communicates fairness to both partners.

Psychoeducation

Psychoeducation about divorce, and about better and worse ways of divorcing, is a cornerstone of most intervention in divorce. Inaccurate information proliferates, most especially about normative feelings and behavior.

One important focus for psychoeducation is the range of feelings and behaviors that typify families going through divorce. Hetherington (1999) succinctly described a core aspect of divorce for divorcing partners as being what she termed the "not me" experience—the feeling that "I am not feeling or acting in the usual way I experience myself." Divorce or separation is a time of numerous overlapping changes: not only ending what is the core anchoring relationship in Western culture but also changes in living arrangements, finances, daily routines, relationships with extended family members (some of whom technically are no longer family), and innumerable other factors. Helping clients understand that such feelings of disequilibrium are typical and yet do, for most people, resolve over a period of 6 months to 2 years helps promote a sense of balance.

A second important focus of psychoeducation with partners who have children centers on the typical reactions of children. Perhaps most crucial here is to deal with the common mythology about the inevitable damage inflicted on children by divorce. Yet clients must also understand that children almost invariably have strong feelings and considerable pain about their parents' divorce, and often find complex ways to speak to that pain (e.g., in joining with one parent by disparaging the other). The most useful psychoeducational message here orients parents to children's feelings and ways to communicate about those feelings. Parents should be helped to understand the likely short-term impacts of divorce on their children and to monitor for the emergence of problems, yet ultimately to remain hopeful about children's resilience in the wake of this life stress.

Couples in divorce therapy typically look for professional input about how to deal with their children relative to the divorce. Although suggested guidelines for parents vary with the situation (e.g., high- and low-conflict families differ in the advisability of having whole-family meetings to discuss the divorce), some clearly transcendent principles are broadly applicable. Foremost is avoiding persistent, acrimonious conflict about the children, especially in the children's presence, and/or setting up triangles in which they are involved. A second guideline is to maintain as much stability in the children's lives as possible. Considerable research has shown that multiple changes increase risk for children (Hetherington & Kelley, 2002). A plan for a stepwise process of absorbing change is preferable to having children suddenly find themselves in a remarriage family in a new house and school.

Finding good ways for parents and children to communicate about the divorce also makes a difference. Children process the concept of divorce through the lens of their developing understandings; therefore, explanations must consider the children's developmental stages. Because children often tend to blame themselves for the divorce of parents and fear a rupture in their connection with one or both parents, it is helpful for parents to reassure children that the parents are not divorcing because of them, and that the future involves the parents' being apart, not a separation between parents and children. Children also tend to become upset about parents' denials that life is changing. Messages that minimize or disregard the fact that something major is happening fly in the face of the obvious understanding that close relationships are in the process of changing. The best communication both empathizes with and reassures children.

Another focus of psychoeducation centers on typical feelings that partners have toward soon-to-be-former partners. The task involved in divorce is unique among human challenges: to disconnect from the person to whom one formed (at least at one time) a primary bond. Feelings such as anger and contempt are helpful in this radical act of excising such a core attachment; yet such feelings, especially when accompanied by hostile action, readily lead to a symmetrical sequence of escalating conflict that is bad for everyone. This translates into messages in therapy that not only promote the exploration of feelings (given a relationship that can support that exploration) but also help clients find ways to process these feelings when present.

Maintaining a Solution-Oriented Focus

Divorce is a life transition that calls out for solutions rather than an endless problem focus. That frame is invaluable in achieving progress.

Orienting to Change and Motivational Interviewing

In divorce, the problem is often externalized into the other. Motivational interviewing can be invaluable in helping partners orient to how they might have a role in the problem or benefit from doing something to make this transition easier.

Implementing Behavioral Solutions

The toolkit of behavioral skills sets can be essential to the success of divorce therapy. Often clients lack requisite skills needed, or processes needed for successful problem solving (e.g., communication) have eroded. As simple an intervention as acknowledging one another when children are exchanged can make for important differences. The good news for those who have struggled with such skills sets in their marriages is that the skills sets required for successful divorce are more limited than those in successful marriage.

Negotiation and Problem Solving

Negotiation is not only the central ingredient in mediation, but it is also an important aspect of divorce therapies. The challenges in negotiation are clear. Partners who often have not negotiated well in marriage are now called on in the context of a stressful transition to settle many issues, such as the time each partner will spend with the children after divorce.

Mediators offer a highly structured process for negotiation. The application of negotiation principles in the therapy room mirrors much of what occurs in mediation. Yet there are some differences. Given therapy's broader mandate, more time can be devoted to enhancing the partners' skill in negotiation, allowing for the creation of a process that can last into the future. The negotiation process best initially follows the problem-solving component of a cognitive-behavioral couple therapy (also see Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), with attention to other factors (e.g., emotion regulation) that influence problem solving.

Establishing Reliable, Rule-Driven Methods of Communication and "Good-Enough" Coordination

As partners begin to divorce, ground rules change for life as a couple and as separate individuals. Among the first matters to be negotiated are these ground rules: What are the expectations over the short run about such matters as other partners, financial responsibilities, time together, and communication?

When the partners have children, a vehicle for communication needs to be created that can transcend the time of the divorce. In low-conflict situations, this may merely involve reviewing possible formats and deciding on a structure for communicating. However, when there is a high level of either conflict or disengagement, a crucial task lies in building reliable, safe, and agreed-upon methods of communication and coordination.

A realistic expectation for high-conflict cases is that the different households will function independently, with only a minimum of communication and coordination, except in those special circumstances that necessitate coordination. In the context of high conflict, more contact typically makes for greater difficulty. Ordinary notions of processing easily degenerate into conflict or nonverbal expressions of contempt. Here, it is useful to teach and practice a variation of the familiar speaker–listener technique involving only a few crisply delivered, rule-governed exchanges (Diamond & Lebow, 2016). When differences between households present special difficulties (e.g., about radical differences in family rules), or when children present with issues that render coordination imperative (as in diabetes or attention-deficit/hyperactivity disorder), more communication may be needed, but the therapist aims to create just enough coordination for children to go on with their lives successfully.

Disengagement Skills and Anger Management

In high-conflict situations, the ability to disengage is as important as the ability to engage. Intrusive behavior is often justified as only an attempt to communicate about important matters. Anger management skills training is a crucial strategy in high-conflict divorce. Clients are taught and practice skills for respectfully disengaging from conflict, such as ways of responding to challenging behaviors and statements, as well as selective and appropriate (as opposed to provocative) use of time-out. Anger management may also involve learning to understand the meaning of and control indirect forms of provocation, such as passive–aggressive action, as well as the more obvious angry outbursts (Karam & Lebow, 2006). In many cases, achieving these ends requires not only behavioral practice but also a focus on attributions, emotions, and individual dynamics.

Reattribution and Narrative Change

Negative attribution, in which a partner assigns the worst possible meaning to the other's behavior (typically seeing that behavior as intentional, indicative of a personal defect, and subject to internal locus of control), plays an essential role in most couples' divorces. Most benignly, these attributions create distance, reaffirm the positive meaning of ending the relationship, and mitigate a sense of loss. However, there are times when such attributions extend well beyond a simple distancing and become an aspect of intractable conflict. In such cases, each partner comes to view most of the other's actions through a negative filter, in which problematic actions by one partner are invariably viewed as evidence of character flaws and/or hostile action, whereas constructive behavior is seen as disingenuous or transitory. For example, a mother, faced with evidence that her separated spouse had become abstinent in the use of alcohol and a faithful attendee of Alcoholics Anonymous, attributed these changes to his desire to win his court case; she remained convinced that the alcoholic behavior would return as soon as the court proceeding was completed. Children, extended family, and friends in high-conflict cases often easily become caught up in similar patterns of selective attribution (Johnston & Campbell, 1988).

Strategies from both cognitive and narrative approaches (also see Chapter 3, "Cognitive-Behavioral Couple Therapy," by Baucom et al., and Chapter 10, "Narrative Couple Therapy," by Freedman & Combs, both in this volume) such as challenging beliefs, creating new narratives, and testing the evidence for attributions provide antidotes to such patterns. For example, when one parent sees children's upset as a direct function of the other parent's behavior, but this interpretation does not appear to be consistent with a balanced view, the therapist can work to help frame a new narrative that emphasizes other sources for the distress (e.g., children's powerful feelings about separation, the natural difficulties of learning to live in two households, or memories about old events). However, it remains crucial in these cases for discussion of behavior, cognitions, and affect to be linked. Positive reattribution is not therapeutic if the parent about whom the attribution is made continues to present ongoing dangers; in that case, the therapist must first focus on helping that parent to become less dangerous, and the other parent and children to differentiate between behaviors that present threats and those that do not.

Mindful Acceptance

Third-wave behavioral methods centered on acceptance also have a crucial role in this work (also see Chapter 4, "Integrative Behavioral Couple Therapy," by Christensen, Dimidjian, Martell, & Doss, and Chapter 5, "Acceptance and Commitment Therapy for Couples," by Lawrence, Cohn, & Allen, both in this volume). Therapists help partners to distinguish between what can be changed and what cannot, and to employ mindfulness and related techniques to help with adaptation when changes wished for are not possible.

Catharsis

Divorcing couples typically feel traumatized and injured. Therapy can be a safe place to share such strong feelings. Such sharing can have considerable benefit. For example, when a partner is leaving for another relationship, the "left" partner often feels relieved and supported through sharing feelings that are witnessed by the therapist. Similarly, for partners who have not been able to express their feelings about divorce, such expression may be a key event in working through feelings about the divorce.

However, catharsis in the couple context may or may not be helpful, depending on the couple. In high-conflict couples, such shared feelings have already been expressed many times over, and further sharing often devolves into increased conflict and despair. In such couples, catharsis is better reserved for separate individual sessions (with a goal of expressing feelings there, so that less such expression is directed toward the partner), or for individual therapy with another therapist in which the agenda at least in part is to express and work with feelings of hurt and anger. Even in less conflict-laden couples, patterns of the same cathartic experience repeated many times are more likely to end therapy than lead to progress.

Mentalizing

An understanding of the couple psychodynamics that inform partners' present circumstance is invaluable in helping plan for effective intervention. Among more active psychodynamic techniques, the encouragement of each partner finding (mostly again, but sometimes for the first time) an ability to mentalize the other has greatest utility in this context (also see Chapter 8, "Mentalization-Based Couple Therapy," in this volume, by Bleiberg, Safier, & Fonagy). Finding some empathy for the other can facilitate other changes needed.

Reviewing the Marriage

Divorce is a time of ending the story of a couple's life together. In the best of circumstances, partners review their history together and the decision to part in the wake of that history. Some couples can utilize such discussion as a springboard to working through long-standing feelings, although such work should be reserved for those who are ready to more fully process their experience.

Expanding into Other Formats

EXPLORING INDIVIDUAL ISSUES

Addressing the individual histories of the partners and their internal conflicts represents a complicated territory in divorce therapy. Few clients enter such a therapy looking to do this kind of exploration; other issues predominate. This work is typically easier to initiate when a couple therapy has morphed into divorce therapy, and the precedent and alliance for this kind of work are already established. In high-conflict situations and many other variations on the demise of a relationship, the context of couple therapy is not likely to be a safe place for such exploration.

Having said this, the transition of divorce is a time in which reflection about self is almost always valuable. At its most cooperative and profound, divorce therapy can focus on how a couple reached this point and how both partners and their process contributed to the demise of the marriage. The insights that accrue for each partner about self can then be the focus of later exploration, in and out of therapy. In most instances, such exploration of "deeper" individual feelings about self and the meanings of life events occurs in a concurrent individual therapy. At times, some of this work can be done conjointly or in a limited number of individual sessions with each partner.

WORKING WITH CHILDREN

Divorce is an event that affects not only the couple but also the family. It is common, but unwise, to treat couple divorce therapy as fully separate from the lives of children. There are several ways that the needs of these children can be reflected in couple divorce therapy. Typically, part of the divorce therapy agenda with parents is to address the needs of children (indeed, some divorce therapies focus primarily on parents working with children and on parents establishing working parenting plans; Drozd et al., 2016). Often, a collaborative relationship may be established with another therapist who sees the children in conjunction with the couple therapy. Occasionally, children participate in family sessions with the couple therapist or another therapist. It is essential to emphasize that children are very much part of most divorcing systems; whatever the format, and whether present or not, they are inevitably affected by and a part of divorce therapy.

The need to involve minor children directly in therapy is greater in high-conflict situations or in cases when the children themselves manifest strong signs of difficulties in relation to the divorce. High interparental conflict that focuses on children is sometimes associated with problematic relationships between parents and children. When this is the case, family therapy is indicated to promote better parenting and parent–child connection, and thereby create the possibility of reduced levels of interparental conflict. Sessions that occur between parent and children typically focus on building or rebuilding bonds, reducing the level of conflict, and dealing with problematic behaviors. Almost inevitably, this means that parents must first find a way of understanding how their behavior is perceived by their children, and then be open to the possibility that this behavior can change. To this end, the best chance for success typically pairs feedback offered in individual sessions with parents about how their behavior is experienced, with recognition and support of their positive intension. Helping set boundaries for who talks to whom about what problems provides a foundation for such work, particularly when a difficult parent–child relationship is fueled by direct or indirect discomfort about that relationship by the other parent (Kelly & Johnston, 2001).

Work with children must always be framed in the context of each child's stage of development. Explanations and understandings appropriately vary with age. It must be added that divorce often affects adult children strongly, and similar directions may be helpful in work with parents and their adult children.

WORKING WITH EXTENDED FAMILY MEMBERS

The families of origin and new partners of parents in a family also are strongly affected by and influence the level of conflict in divorce (Johnston & Campbell, 1988). In high-conflict situations, these effects may be so pronounced that involvement of extended family members in treatment may be necessary. Such involvement is most beneficial when partners who are subject to conscious or unconscious pressure from families to remain in conflict are unable to deal with such pressures, and when family members have the personal resources to exert a calming effect on the conflict.

Integrating Strategies in Treatment

Integrating the strategies described earlier is the art of working with divorcing couples. Divorcing couples are alike only in that they are getting divorced; they come to treatment as very different people and with a wide array of issues, difficulties at various systemic levels, and vast differences in the acceptability of various kinds of intervention. Thus, treatment plans vary enormously with reference to which strategies are employed and when they are utilized in treatment based in the specific formulation that emerges for each couple.

However, a few generalizations are possible. Almost all couples benefit from some psychoeducation and from the generation of positive behavioral exchanges. In high-conflict situations, only the less vulnerability-evoking behavioral, structural, and cognitive strategies may be possible. Anger management is almost always an essential ingredient in treatment of high-conflict cases. In more psychologically minded couples who want to mourn the loss of their relationship and learn from it, strategies that access feeling, emotion, and insight are both possible and preferable.

Special Challenges and Arrangements

Difficulties over Child Custody and Visitation

Conflicts over child custody and visitation are among the most pathogenic situations families face. This problem combines several stressors: The family structure is unclear; children are triangulated between parents; and others (including family members, friends, and lawyers) readily become involved in these complex disputes. This subset of divorcing parents (estimated at 5–10%) remains mired in intractable conflict over extended periods. For these high-conflict families, an intensive treatment strategy is needed. Typical methods of therapy, such as unmitigated support and uncoordinated efforts at helping, become iatrogenic in these cases.

Elsewhere, I discuss in detail adaptations that need to be made in these cases (Lebow, 2019). Most important are coordination with other mental health providers and the judicial system and targeting goals for a "good-enough" parent system in which there is little contact between the parents.

Leverage from the court is typically essential in these cases. Often clients are in treatment primarily because of a desire to make a good impression in Court or to respond to the Court's orders. The Court can and typically does make it very difficult not to engage in or cooperate with a mandated treatment. This leads to adaptations in the therapy contract. Clarity about the kinds of information that will be shared with representatives of the Court is essential. Such a contract calls for confidentiality to be maintained in relation to others outside the legal system (as it would in other cases), with the understanding that a special relationship will be established with the Court and attorneys who represent the children. Such a contract also specifies that the general level of client cooperation will be reported to the Court and attorneys, and that there will be more specific sharing with the attorney for the children or guardian *ad litem* (if there is one) about the status of the therapy and court case, and with each adult client and their own attorney (there is no sharing about one parent with the other parent's attorney). This set of ground rules enhances external pressure, which typically is needed to enhance motivation in these cases.

A second crucial aspect of these cases is active coordination with attorneys and mental health treatment providers. Such coordination is preferable in all cases, but here negative effects abound whenever there is a lack of coordination. For example, it is not atypical for an individual therapist involved in treating one partner to become convinced about the provocative nature of the behavior of their client's partner and to support behavior by their client that from a systemic perspective is problematic. Coordination mitigates the likelihood of such isomorphic difficulties emerging in the treatment system.

It also is essential in these cases to rein in goals to ensure that they are attainable. In these systems, it is rare that conflicts are ever actually resolved. Goals that involve distance between parents, minimal communication, and quiet exchanges are most easily achievable. Nonetheless, achieving even these ends requires much change at many levels, which in turn necessitates the use of a variety of the treatment strategies described earlier.

The Interface between Divorce Therapy and the Judicial System

Divorce occurs in various venues, one of which is the legal system. Therefore, the interface with the legal system becomes an aspect of these clients' lives and thereby of the divorce therapy in which they participate. For many, the interface may be an occasional blip (e.g., an unexpected filing received by one partner) to be processed, but the judicial interface becomes crucial when legal matters involving child custody or finances become intense or stalled. The adversarial context of much of the judicial system provides endless opportunities for confrontations in pleadings, subpoenas, depositions, and court appearances, frequently engendering conflict. Furthermore, what transpires on these occasions becomes evidence for negative attribution. Many months of cooperative behavior easily is undone in the context of a disconnected behavior initiated by attorneys in court. In the context of interviews with judges and attorneys, children also can become highly polarized about their best interests. Although judges typically intervene to mitigate conflict, and attorneys often do so, such measures can be met with resistance, sometimes even leading to parents' engagement of new attorneys or petitioning for a change in judges.

In the best divorce therapy with clients with a considerable interface with the legal system, therapists work closely with attorneys and the court to understand what is transpiring within the judicial process and help the court understand the therapy process. Through working in concert with the judicial system, the therapist can anticipate court appearances and develop ways of dealing with these events to minimize the trauma that may occur. In particular, attorneys who serve the children typically welcome such coordination and are prepared to intervene actively to support the therapy process. Attorneys for the parents and the court frequently also are prepared to provide such support.

Utilizing the leverage of the court has risks. Such reporting, even with the best communication, presents chances for inaccurate transmission in the therapist–attorneys and court–clients pathways; such miscommunications can readily lead to alliance ruptures in which the accuracy of information or meanings conveyed are questioned. And there are other risks to the therapeutic alliance. Accurate negative information being conveyed may also result in split alliances. The presence of such feedback can engender what seems to be overt cooperation on the part of one or both partners coupled with covert hostility, or a runaway, symmetrical escalation of conflict between the therapist and one partner.

Yet such leverage is almost always needed in high-conflict cases. Greenberg and Gould (2001) have nicely described the important role of what they term the "treating expert," who interfaces with the judicial system in these cases, serving both the judicial system and the treatment. The value of transmitting crucial information in clear, concise, nonpathologizing language cannot be underestimated. It also is essential for clients to fully understand what information is being shared about them and with whom it is being shared. Some lawyers clearly utilize such information in better ways than others; over time, in working in this role, a therapist evolves a sense of how information is likely to be used by different individuals. As a rule of thumb, such sharing is far easier with attorneys for children or with the court, and riskier with attorneys for the partners.

Residing in the Same House

One of the most problematic situations encountered in divorce therapy occurs when a couple shares a single household over a lengthy period, while in the active process of divorcing. The legal system often makes it difficult to alter this situation, with lawyers frequently advising not leaving the marital home until matters of money and child custody are resolved. In this context, even the most motivated couples typically wear down, and conflict ensues. These life situations lack virtually any positive sentiment override (Gottman, 1999), coupled with much negative sentiment override and many problems that need to be processed.

Such situations call for clear negotiation of rules and roles. When conflict is high, ground rules about time with children and other responsibilities are needed, much as if the partners did not live together. In this way, expectations can be clearly specified, and points of contact and conflict between the partners can be kept to a minimum.

Violence

When one or both partners present with histories of relational violence, special measures must be taken to minimize contact between the parents, both in and out of sessions. In such cases, conjoint meetings are often contraindicated. It is important to bear in mind that divorce is often a time when even persons with no history of violence engage in violent confrontations, and that rates of intimate partner violence are typically underreported. Intrafamilial violence should always be a focus of inquiry. In high-conflict child custody disputes, or in cases when there is a history of couple violence or child maltreatment, the therapist must place a major emphasis on safety.

The Possible Transition from Couple Therapy to Individual Treatment in Cases Ending in Divorce

When couple therapy ends in divorce, what is the responsibility of the couple therapist to the respective partners? This question represents one of the most complex ethical issues confronting couple therapists (also see Chapter 31 on ethical issues, in this volume, by Margolin et al.).

From the Olympian heights of most theories of couple therapy, the couple therapist is the therapist to the couple system, with equal responsibilities to both partners. Based in this well-considered viewpoint, the couple therapist should remain the therapist to the couple, regardless of how the couple relationship develops or whether both partners are willing to remain in couple therapy; therefore, partners are to be referred to someone else for individual therapy, if individual therapy is desired. In this way, triangulation is kept to a minimum, and the alliances remain balanced if the couple chooses to return to treatment.

Yet when divorce ensues, a series of changes in situations and feelings may be launched that at times renders such a decision clinically questionable. For example, when one partner abandons the other and the therapy, the couple therapist, by being unwilling to continue to see the abandoned partner, leaves that partner subject to a second abandonment by the therapist—a decision that cannot feel "therapeutic" and usually is not. Indeed, a partner who is contemplating leaving a relationship may even enter couple therapy with a covert agenda, so that the at-risk partner is engaged with a therapist when the bad news comes. Such situations call for something more than simple, absolute boundaries around the transition from couple to individual therapy. The subsequent work in individual therapy often turns out to be quite special because the therapist has been witness to a major life trauma and has seen the real-life relationship.

Having said this, not all couple therapists would agree with the wisdom of making such a transition. Even for those open to making such a decision to continue with a partner in individual therapy, this transition should only occur with a full consideration of the ethical dilemmas of the situation. A partner who is leaving a relationship also has feelings and an alliance with the therapist. It is always wise to obtain this partner's consent to this transition before making it, and to be sure that consent is truly informed. Such a transition is ripe with opportunities for transference and countertransference (particularly insofar as the demise of the marriage may be seen as the therapist's failure), and such potential transferences and countertransferences need to be examined carefully.

MECHANISMS OF CHANGE

Curative factors in divorce therapy depend on the therapist's establishing an alliance that will permit a divorcing couple to process the heightened emotions and address the numerous tasks of this time of life. The common factors of being able to place current events in a developmental framework, instill hope for future recovery, engage a sense that help is available, and bring calm to what feels chaotic are also crucial (also see Chapter 13, "Common Factors in Couple Therapy," in this volume, by Davis). The simpler strategies of intervention that I described earlier, such as skill development, psychoeducation, reframing, and promoting positive exchange, have utility in conjoint sessions in most cases. Other strategies, which push deeper into individual thoughts, feelings, and dynamics, are best left for situations with highly motivated clients looking to truly work through their differences or for individual sessions that augment the conjoint work.

The therapist's role in divorce therapy is intrinsically a difficult and stressful one. There is much trauma and pain, and the ending is never unambiguously happy. Even the best therapy may well be in part a disappointment to both partners, who long for confirmation of the wisdom of their choices. Alliance ruptures may be frequent. Remaining empathic and holding a multipartial alliance are essential. The therapist must take comfort in helping couples successfully engage in a therapy that helps them move through this transition with the least damage and the most growth possible. Working with divorcing couples is a high-stress activity that calls for therapists to continually process their interface, be aware of secondary traumatization, and maintain their balance through self-reflection and self-care.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Perhaps due to a political climate (in the United States, at least) that renders government funding of research on divorce virtually nonexistent, to date, there have been no studies of the impact of divorce therapy. Research on psychoeducational prevention programs (Schramm & Becher, 2020) and mediation (Emery et al., 2005) does offer research support for some of the strategies described here. For the present, all we can do is note that clients, judges, and lawyers typically regard divorce therapy as essential, and that the strategies discussed in this chapter have a strong evidence base in related difficulties (e.g., anger management). Research does show that couple therapies have a positive impact on couples considering divorce (Lebow, Chambers, Christensen, & Johnson, 2012).

CASE ILLUSTRATION

Todd and Susan married when they were both 30. They had what they both regarded as an excellent relationship until they had their first child at 35. From that time onward, Todd became increasingly unhappy with the relationship. He felt Susan was overinvolved with the children and had little time for him. In turn, Susan became critical of Todd's parenting and his increasing absence.

After 15 years of marriage and several years of mutual withdrawal and criticism, Todd announced to Susan that he wanted to divorce. He told Susan that his mind was made up and he had already talked to a lawyer. When told this, Susan became enormously upset, accusing Todd of abandoning her and the children. Although furious, she also told him that she remained fully committed to saving the marriage, adding that if he did this, he would have no cooperation from her about seeing the children or the arrangements for a divorce.

It was at this point that Susan and Todd sought couple therapy. The first task in the therapy was clearly one of discernment: Todd was ready to exit and Susan was not. Here, even though there was so much that might inform their couple work, the process was simple and straightforward. Although this probably was a marriage that could have been improved several years earlier if they had dealt with their complex issues around gender, having children, turning toward and turning away, Gottman's (1999) four horseman (criticism, contempt, stonewalling, and defensiveness), attending to their sexuality, mentalizing each other, and strengthening their attachment outlined in the other chapters in this book, Todd had long ago exited from the marriage. Indeed, it seemed clear that Todd had already been looking for a new partner and, while he denied any other present relational involvement, he had become close with a work colleague. Thus, Todd was consistent in the conjoint meetings and meetings with the therapist alone that he was only looking to leave the marriage.

In the first phase of the therapy, as this information was reflected to the couple, Susan was alternately extremely hurt and rageful to Todd about this, letting him know how angry she was that he was leaving the marriage without working on it, that he was ruining her life, and that leaving the marriage would mean that they would have a miserable divorce process and he would not see their children. Susan also proceeded to share with the children that Todd was leaving them and had a new relationship.

Couple therapies often end at the point of such an impasse, with each partner falling back on their respective support systems and ultimately attorneys, fueling further conflict. However, Susan and Todd both cared about their children, so when the therapist raised to them the risks involved in ending therapy in this state of flux, each was willing to continue.

Thus began the second phase of the work. With it no longer in focus that the marriage might be preserved, was there a way to exit without it being maximally destructive for all? This phase began with a major regression in which Susan formed an alliance with the children against Todd and actively encouraged their staying away from and being oppositional toward Todd. Susan also became significantly depressed. Todd first made bids for time with the children, then as he filed for divorce, he began to initiate petitions to mandate the children to spend time with him. At home, Todd and Susan barely communicated, their only contact consisting of occasional heated arguments.

Thus, each entered the second phase with considerable anger and despair. The primary therapeutic initial task therefore became finding a way to slow the process down and begin to see whether there might be a way out of the emerging cascade into chaos. The therapist spent the next few conjoint sessions focused on just that, not only allowing each partner time to speak and share some of their affect but also intervening sharply to reestablish control when a speech turn started to move toward disaster. The therapist drew from the toolkit for anger management, slowing the process, empathizing with how difficult the situation was for each of them, framing this as a difficult time they needed to work through, accentuating speaking and listening, suggesting moments to breathe and be mindful, and to see if there might be a better way to communicate.

The therapist interspersed break-out individual meetings with each partner during which they would not only be able to fully express themselves but also might be able to able to find a mind-set in which they might be able to consider alternatives. In the individual meetings, the therapist offered support but also provided a frame based in psychoeducation about the nature of such conflicts and the difficulty posed for everyone, most especially their children, whom both maintained they wanted to protect. In those meetings as well, the therapist was able to help both Todd and Susan to engage in motivational interviewing and a Socratic dialogue with themselves about their own behavior. Was this how they wanted to see themselves behave? Was this how they wanted to have their children experience them? Did they experience themselves as having choices about how to act or were they being driven by some other part of their brain? Fortunately, both Todd and Susan were able to see their own behavior as out of kilter with their ideal image of themselves. There even were glimmers of being able to mentalize the other (their levels of contempt and mutual indifference came out of hurt and a sense of abandonment more than deep mutual hatred). Given Susan's individual symptoms and level of pain, it was relatively easy to convince her to see an individual therapist to deal with that pain, her reactive depression, and her challenge to find a new life plan. Todd was less interested in such deeper work, but he had a practical side that clearly wanted the symmetrical escalation to stop.

Given this, the conjoint work then was able to refocus on how to reduce the present conflict and find more successful ways to disengage. As noted, both were concerned about their children, and a plan was formed for the children to see a therapist as well to help them with their feelings about the separation. The therapist arranged for a systemically focused therapist to do this work, to help the children with not only their feelings and life transition but also a clear sense that there was little long-term payoff for anyone joining in their mother's fight with their father. The couple therapist remained in close contact with Susan's therapist and the children's therapist throughout the treatment.

The conjoint meetings also began to focus on practical ways they could share the house during this time of waiting to divorce. With considerable coaching focused on the children's best interests and anchored in the narrative that the future lives of the children would mostly be primarily with her, Susan began to stop discouraging the children to spend time with their father. With similar help, Todd could reassure Susan that she would continue to be now and for the future the principal parent figure in their lives. As this conflict ebbed, Todd arranged to move out, and the lawyers set a plan for "father time" (every other weekend and one midweek time together each week) with the children. With further in-session communication and negotiation, Todd and Susan established some ground rules for consistency in their parenting with each of them.

Having established a good-enough working relationship with one another, neither Susan nor Todd was up for mourning the loss of their relationship together. Susan would do this elsewhere and it did not seem something in which Todd had much interest. The couple decided with the attorneys and based in their work in therapy to have joint custody of their children, while they principally lived with their mother. The financial aspects of their divorce also went smoothly. At the point of arriving at this peace, they terminated couple therapy.

In summary, this therapy with Susan and Todd did not result in a resolution of all their feelings toward one another or the "Hallmark" version of uncoupling. However, it did create the space to free themselves from the free fall into which they had entered and were taking their children. The good news was that they were able to draw on constructive, resilient parts of themselves not so apparent in the moment of the crisis of splitting up at the beginning of therapy that allowed for them to remain open to the intervention strategies aimed at helping them and the family system restore balance. Additionally, they were willing and able to engage other resources (e.g., therapists for Susan and the children, and attorneys) that were helpful in moving toward a systemic solution. Not all couples and families in similar circumstances can do this; for some, the free fall lasts forever, or at least for many years. Systems are endlessly engaged in pathways of recursive influence. When one person can become more settled, it creates the conditions under which others may as well. Of course, this represents a very complex human operation: to be able to experience your feelings and your pain while also retaining enough balance to remain open to therapy that promotes coping, as well as individual and systemic functioning. These are far from easy tasks in the context of ending what had been thought to be life-long relationships. Any help couple therapy can offer in that direction has great value for couples and their families.

CONCLUDING COMMENTS

Divorce and other forms of relationship dissolution represent a crucial consideration in couple therapy. Divorce often hovers as a stated or unstated possibility in therapy, and as a much different possible outcome than resolving relationship issues. Furthermore, there is a great need for therapy helping couples to divorce well or, at least, to avoid or mitigate the potential cascade into divorce havoc. All couple therapists need to develop a skills set for working with the topic of divorce in couple therapy, and there is a vitally important subspecialization in working with those who are divorcing, most especially those with high levels of conflict or cutoff. This latter divorce therapy optimally draws from a broad, integrative therapeutic skills set to minimize the short- and long-term impact of divorce and promote coping and growth through this life transition.

SUGGESTIONS FOR FURTHER STUDY

Ahrons, C. R. (1994). *The good divorce: Keeping your family together when your marriage comes apart*. New York: HarperCollins.

Doherty, W. J., & Harris, S. M. (2017). *Helping couples on the brink of divorce: Discernment counseling for troubled relationships*. Washington, DC: American Psychological Association.

Drozd, L., Saini, M., & Olesen, N. (2016). *Parenting plan evaluations: Applied research for the family court* (2nd ed.). New York: Oxford University Press.

Emery, R. E. (1999). *Marriage, divorce, and children's adjustment* (2nd ed.). Thousand Oaks, CA: SAGE.

Hetherington, E. M., & Kelly, J. (2002). *For better or for worse: Divorce reconsidered*. New York: Norton.

Lebow, J. L. (2017). *Working with issues in divorce* [DVD]. Washington, DC: American Psychological Association.

Lebow, J. L. (2019). *Treating the difficult divorce: A practical guide for psychotherapists*. Washington, DC: American Psychological Association.

REFERENCES

Ahrons, C. R. (1994). *The good divorce: Keeping your family together when your marriage comes apart*. New York: HarperCollins.

Ahrons, C. R. (2004). *We're still family: What grown children have to say about their parents' divorce*. New York: HarperCollins.

Amato, P. R. (2010). Research on divorce: Continuing trends and new developments. *Journal of Marriage and Family, 72,* 650–666.

Amato, P. R., & Afifi, T. D. (2006). Feeling caught between parents: Adult children's relations with parents and subjective well-being. *Journal of Marriage and Family, 68*(1), 222–235.

Amato, P. R., & Booth, A. (2002). A generation at risk: Growing up in an era of family upheaval. *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 486–487.

Auersperg, F., Vlasak, T., Ponocny, I., & Barth, A. (2019). Long-term effects of parental divorce on mental health—A meta-analysis. *Journal of Psychiatric Research, 119,* 107–115.

Baude, A., Pearson, J., & Drapeau, S. (2016). Child adjustment in joint physical custody versus sole custody: A meta-analytic review. *Journal of Divorce and Remarriage, 57*(5), 338–360.

Buchanan, C. M., Maccoby, E. E., & Dornbusch, S. M. (1996). *Adolescents after divorce.* Cambridge, MA: Harvard University Press.

Buehler, C. (2020). Family processes and children's and adolescents' well-being. *Journal of Marriage and Family, 82,* 145–174.

Cherlin, A. (2010). Demographic trends in the United States: A review of research in the 2000s. *Journal of Marriage and Family, 72,* 403–419.

Diamond, R. M., & Lebow, J. L. (2016). Rule-governed speaker–listener technique. In G. R. Weeks, S. T. Fife, & C. M. Peterson (Eds.), *Techniques for the couple therapist: Essential interventions from the experts* (pp. 51–55). New York: Routledge/Taylor & Francis Group.

Doherty, W. J. (2001). *Take back your marriage: Sticking together in a world that pulls us apart.* New York: Guilford Press.

Doherty, W. J., & Harris, S. M. (2017). *Helping couples on the brink of divorce: Discernment counseling for troubled relationships.* Washington, DC: American Psychological Association.

Drozd, L., Saini, M., & Olesen, N. (2016). *Parenting plan evaluations: Applied research for the family court* (2nd ed.). New York: Oxford University Press.

Emery, R. E. (1999). *Marriage, divorce, and children's adjustment* (2nd ed.). Thousand Oaks, CA: Sage.

Emery, R. E. (2004). *The truth about children and divorce: Dealing with the emotions so you and your children can thrive.* New York: Viking.

Emery, R. E. (2012). *Renegotiating family relationships: Divorce, child custody, and mediation* (2nd ed.). New York: Guilford Press.

Emery, R. E., & Dinescu, D. (2016). Separating, divorced, and remarried families. In T. L. Sexton & J. Lebow (Eds.), *Handbook of family therapy* (pp. 484–499). New York: Routledge/Taylor & Francis Group.

Emery, R. E., Sbarra, D., & Grover, T. (2005). Divorce mediation: Research and reflections. *Family Court Review, 43,* 22–37.

Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy.* New York: Norton.

Gould, J. W. (1998). *Conducting scientifically crafted child custody evaluations.* Thousand Oaks, CA: Sage.

Greenberg, L. R., & Gould, J. W. (2001). The treating expert: A hybrid role with firm boundaries. *Professional Psychology: Research and Practice, 32,* 469–478.

Greene, S. M., Anderson, E. R., Hetherington, E., Forgatch, M. S., & DeGarmo, D. S. (2003). Risk and resilience after divorce. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 96–120). New York: Guilford Press.

Hadfield, K., Amos, M., Ungar, M., Gosselin, J., & Ganong, L. (2018). Do changes to family structure affect child and family outcomes?: A systematic review of the instability hypothesis. *Journal of Family Theory and Review, 10,* 87–110.

Harold, G. T., & Sellers, R. (2018). Annual Research Review: Interparental conflict and youth psychopathology: An evidence review and practice focused update. *Journal of Child Psychology and Psychiatry, 59,* 374–402.

Hetherington, E. M. (1999). *Coping with divorce, single parenting, and remarriage: A risk and resiliency perspective.* Mahwah, NJ: Erlbaum.

Hetherington, E. M., & Kelly, J. (2002). *For better or for worse: Divorce reconsidered.* New York: Norton.

Johnston, J. R., & Campbell, L. E. (1988). Tribal warfare: The involvement of extended kin and significant others in custody and access disputes. *Conciliation Courts Review, 24,* 1–16.

Johnston, J. R., & Roseby, V. (1997). *In the name of the child: A developmental approach to understanding and helping children of conflicted and violent divorce.* New York: Free Press.

Johnston, J. R., Walters, M. G., & Olesen, N. W. (2005). The psychological functioning of alienated children in custody disputing families: An exploratory study. *American Journal of Forensic Psychology, 23*(3), 39–64.

Karam, E., & Lebow, J. (2006). Couples and family treatment of anger difficulties. In E. L. Feindler (Ed.), *Anger related disorders: A practitioner's guide to comparative treatments* (pp. 165–187). New York: Springer.

Kelly, J. B. (2003a). Parents with enduring child disputes: Focused interventions with parents in enduring disputes. *Journal of Family Studies, 9,* 51–62.

Kelly, J. B. (2003b). Parents with enduring child disputes: Multiple pathways to enduring disputes. *Journal of Family Studies, 9,* 37–50.

Kelly, J. B. (2004). Family mediation research: Is there empirical support for the field? *Conflict Resolution Quarterly, 22,* 3–35.

Kelly, J. B., & Johnston, J. R. (2001). The alienated child: A reformulation of parental alienation syndrome. *Family Court Review, 39,* 249–266.

Krantzler, M., & Krantzler, P. B. (1999). *The new creative divorce: How to create a happier, more rewarding life during—and after—your divorce*. Holbrook, MA: Adams Media.

Lebow, J. L. (2019). *Treating the difficult divorce: A practical guide for psychotherapists*. Washington, DC: American Psychological Association.

Lebow, J. L., Chambers, A. L., Christensen, A., & Johnson, S. M. (2012). Research on the treatment of couple distress. *Journal of Marital and Family Therapy, 38,* 145–168.

Papernow, P. L. (2018). Clinical guidelines for working with stepfamilies: What family, couple, individual, and child therapists need to know. *Family Process, 57,* 25–51.

Pedro-Carroll, J. L. (2005). Fostering resilience in the aftermath of divorce: The role of evidence-based programs for children. *Family Court Review, 43,* 52–64.

Pinsof, W. M., Breunlin, D. C., Russell, W. P., Lebow, J., Rampage, C., & Chambers, A. L. (2018). *Integrative systemic therapy: Metaframeworks for problem solving with individuals, couples, and families*. Washington, DC: American Psychological Association.

Pruett, M. K., Cowan, C. P., Cowan, P. A., Pradhan, L., Robins, S., & Pruett, K. D. (2016). Supporting father involvement in the context of separation and divorce. In L. Drozd, M. Saini, & N. Olesen (Eds.), *Parenting plan evaluations: Applied research for the family court* (pp. 85–117). New York: Oxford University Press.

Raffel, L. (1999). *Should I stay or go?: How controlled separation (CS) can save your marriage*. Chicago: Contemporary Books.

Raley, R. K., & Sweeney, M. M. (2020). Divorce, repartnering, and stepfamilies: A decade in review. *Journal of Marriage and Family, 82,* 81–99.

Sbarra, D. A., Bourassa, K. J., & Manvelian, A. (2019). Marital separation and divorce: Correlates and consequences. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Foundations, methods, and contemporary issues across the lifespan* (Vol. 1, pp. 687–705). Washington, DC: American Psychological Association.

Schramm, D. G., & Becher, E. H. (2020). Common practices for divorce education. *Family Relations, 69,* 543–558.

Steinbach, A. (2019). Children's and parents' well-being in joint physical custody: A literature review. *Family Process, 58,* 353–369.

Thomas, K. W. (2015). *Unconscious coupling: 5 steps to living happily* even *after*. New York: Harmony Books.

Weiner-Davis, M. (1992). *Divorce busting: A revolutionary and rapid program for staying together*. New York: Summit Books.

Weitzman, L. J., Dixon, R. B., Arendell, T., Krantz, S. E., Riessman, C. K., Ahrons, C. R., & Rodgers, R. H. (1992). Divorce and remarriage. In J. H. Skonick & A. S. Skolnick, *Family in transition: Rethinking marriage, sexuality, child rearing, and family organization* (7th ed., pp. 217–289). New York: HarperCollins.

Weiss, R. L., & Cerreto, M. C. (1980). The Marital Status Inventory: Development of a measure of dissolution potential. *American Journal of Family Therapy, 8,* 80–85.

Whitaker, C. A., & Miller, M. H. (1969). A reevaluation of "psychiatric help" when divorce impends. *American Journal of Psychiatry, 126*(5), 611–618.

CHAPTER 22

Therapy with Stepfamily Couples

Patricia L. Papernow

BACKGROUND

The intensity and complexity that couples in "blended families" bring to therapy can be daunting for even senior, experienced clinicians. Principles that may be applicable to first-time couples are often not only ineffective but also even destructive for couples in stepfamilies. In the United States, about 42% of all Americans have a close stepfamily relationship (Parker, 2011). Twenty-six percent of all marriages include stepchildren (Stykes & Guzzo, 2015). The number of families, including stepfamilies, headed by unmarried cohabiting couples has risen substantially throughout most of the world (Sassler & Lichter, 2020). Although divorce and marriage rates have evened out since the 1980s, they are rising steeply among older Americans (Brown & Lin, 2012) with a concomitant rise in later-life stepcouples (also see Chapter 21 on divorce, in this volume, by Lebow).

These numbers tell us that stepfamilies saturate the caseloads of all therapists. Nonetheless, few graduate programs in psychology, social work, psychiatry, or even postgraduate programs in couple and family therapy provide training in this area. This chapter describes the fundamental differences between stepfamilies and first-partner families. It maps out five major challenges that stepfamilies face. It provides evidence-based guidance for meeting each challenge on three different levels: psychoeducational, interpersonal, and intrapsychic/family of origin. Intersectionalities for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ), African American and Latinx stepcouples, and later-life recouplers are explored. The chapter ends with a case study illustrating work on all three clinical levels.

CORE UNDERSTANDINGS ABOUT STEPFAMILIES

What Makes Stepfamilies Different?

Stepfamilies must build their lives together on a fundamentally different foundation from first-partner families. Couples in first-time families usually enter childrearing having had time alone together to build some trust and to develop some shared understandings about "how we do things." In a first-partner family, children enter their parents' established relationship, usually one at a time. They also usually arrive hardwired for attachment to *both* of their parents, and vice versa. If things go well, attachment throughout the family becomes secure and strong and, as the years go by, thousands of details of daily living eventually no longer need discussion.

If things do not go well and the adult couple splits up, children in much of the developed world become part of two single-parent families. Ex-spouses often maintain some common ground. In addition, over time, each single-parent family also begins to develop its own culture. So, imagine that a year or two after his divorce, a dad named Mike begins dating a woman named Anna, and their relationship becomes serious. Like most new couples, Mike and Anna are very much in love. However, unlike a first-time family, this family begins with children on board. Furthermore, in this new stepfamily, and often for many years to come, the powerful, historically rooted channels of attachment, and the shared understandings about "how we do things," lie between the parent, Mike, and his children (and, often, between Mike and his ex-wife)—not within the stepcouple or between the stepparent, Anna, and her stepchildren. A stepparent such as Anna enters the new couple relationship as an outsider to an already established system. This is what I call "stepfamily architecture."

The Five Challenges of Stepfamily Architecture

Stepfamily architecture creates five major challenges to intimate connection:

1. Stepparents are stuck outsiders in the family. Parents are stuck insiders.
2. Children in stepfamilies struggle with losses, loyalty binds, and change.
3. Parents and stepparents are often divided around parenting tasks.
4. Stepcouples must forge a new family culture while respecting already established cultures.
5. Ex-spouses, dead or alive, are a permanent part of the family.

At just the moment when a new stepcouple is looking for delicious connection, these challenges place parents and stepparents in fundamentally different positions that create constant attachment breaks. Furthermore, at a time when children especially need attuned adults, this family structure often puts both parents and stepparents at odds with kids.

The Many Forms of Stepfamilies

Stepfamilies come in many forms. Mike and Anna form what researchers call a "simple" stepfamily (as if any stepfamily is simple) in which only one adult brings children. In "complex" stepfamilies, both adults bring children. Children may be present in the household on a full-time or part-time basis, or neither. The new couple may, or may not, go on to have a child of their own. Stepcouples may be married. Increasingly, they are not. The partners may be just beginning to date, or in a long-established relationship. The adults may be straight or LGBTQ. Children may be young, under 18. Children of older recouplers, though, are adults, some with their own kids. All of these couples have one thing in common: At least one parent–child relationship precedes the adult couple relationship. All face most of the five challenges listed above.

THE PRACTICE OF COUPLE THERAPY WITH STEPFAMILIES

Three Levels of Help

A three-level framework helps to organize clinical work with stepfamilies: psychoeducational, interpersonal, and intrapsychic/family of origin.

The Psychoeducational Level

Systems therapists are usually taught to "attend to the process, not the content." Process is critical in this work. However, stepcouples are often lost in difficult, confusing territory, making one "wrong turn" after another. Providing an accurate map and clear "driving directions" is a crucial part of lowering distress and supporting well-being. On this level, the conversation takes place between the therapist and both members of the couple.

The Interpersonal Level

On this level, the partners are asked to turn to each other. The therapist teaches key interpersonal skills and works to identify and shape patterns of connection and disconnection. Stepfamily architecture pulls for disconnection. All stepcouples face similar challenges. However, those with better interpersonal skills meet their challenges more successfully (Golish, 2003). If you have good couple therapy training, this is the place to put it to work. My own work on this level integrates a number of different models: internal family systems, gestalt therapy, emotionally focused couple therapy (see Johnson, Wiebe, & Allan, Chapter 6, in this volume), and Gottman method couple therapy (see Gottman & Gottman, Chapter 16, also in this volume). When reactivity is high and negative cycles are dominating, therapists need to actively step in to shape experiences of caring connection. This chapter focuses on concrete tools that can be especially effective in helping stepcouples to connect across the constant experiential divides that stepfamily structure creates.

The Intrapsychic/Family-of-Origin Level

On the third, intrapsychic/family-of-origin level, we are asking clients to make a "U-turn" inside

(Schwartz & Sweezy, 2019) to heal family-of-origin wounds that may be making stepfamily challenges especially painful. Stepcoupling is a very bumpy road to intimacy. When stepfamily challenges hit old wounds, the flood of feelings can overwhelm the capacity to respond wisely. Healing those old bruises can lower the emotional temperature enough to enable stepfamily members to meet their challenges. I depathologize this level of work with what I call "Papernow's bruise theory of feelings": "If I bump my arm in a place where the flesh is healthy, it hurts. If there is already a bruise there, it hurts much more. If it is a deep bruise, just touching it can be blindingly painful."

I turn now to describing each of the five challenges and evidence-based guidance for clinical work on each of the three levels of intervention.

First Challenge: Insider–Outsider Relationships Are Stuck and Intense

Any therapist working with stepcouples has likely heard an exchange that sounded something like this:

ANNA (stepmother): Your kids don't talk to me. They don't even look at me.

MIKE (father): Half the time they don't look at me, either. Teenagers are like that!

ANNA: But, Mike, it's like I don't exist. When they're here, you don't talk to me either!

MIKE: What do you expect me to do? They're my kids!

ANNA: (*voice rising*) I'm your *wife*. Don't I *ever* come first?!

MIKE: (*slumping*) Anna, how many times have I said this! *Please* don't make me choose!

Understanding the Challenge

In a first-time family, insider–outsider positions in the adult couple shift back and forth. Sometimes one child is particularly close to Mom or to Dad. A few days or months later, that child suddenly wants only the other parent. Being the left-out parent can be painful. However, both adults in a first-time couple can draw on a history of parent–child and couple attachment that provides some refuge. Familiar habits of daily living also provide multiple pathways for togetherness. Furthermore, in first-time families, adult insider–outsider positions usually shift back and forth between parents.

In stepcouples, insider–outsider positions are stuck. Children want to bring their stories, their excitement, and their disappointments to their parents, not to their stepparents. The easy paths to joint action lie between parents and children, not in the newer steprelationships. As a consequence, every time a child enters the room or the conversation, the stepparent is very often a stuck outsider. Outsiderness leaves most humans feeling left out, uncared for, and invisible. In the dialogue we just heard, Anna says, "It's like I don't exist." This is the anguished cry of a stuck outsider. In contrast, often at the very same moment, the parent is in a stuck insider position. Insiders feel connected, cared about, and engaged, but torn between the people they love. Mike replies, "Please don't make me choose!"—the cry of a stuck insider. This insider–outsider challenge appears early and threads through all of the other four challenges. It often reappears throughout stepfamily life, albeit in softer form, especially at major transitions.

When both members of a stepcouple bring children to a stepfamily, one adult often occupies more of an outsider position than the other. One partner's child may be younger, in less of a loyalty bind, or more easygoing. The other partner's child may be older, in a tighter loyalty bind, more introverted, and/or more overwhelmed by the new family. One parent–child(ren) unit may accidentally dominate the emotional and physical space through sheer numbers, more time spent in the household, or a noisier/more aggressive style. As we will see, minority stigma can add an extra layer of outsiderness for stepparents.

Helping Stepcouples to Meet Their Insider–Outsider Challenges

Shared experiences make for easy empathy. For stepcouples, day in and day out, stepfamily structure places parents and stepparents on opposite sides of an experiential divide. For this reason, empathy and compassion are often in very short supply. Begin by connecting empathically with both sides of the divide. To the stepparent (with the parent listening), the therapist can say, "It is so hard to feel ignored, up close and personal, by a child in your own home." To the parent (with the stepparent listening), "It is so very painful that two of the people you love most in the world are having such a hard time together." Early on, the work moves from affective resonance into a piece of psychoeducation ("I think I can help you understand what's happening here") or interpersonal connection ("Anna, what's it like to hear about how torn Mike feels? Can you let him know what you're getting about how this feels for him?").

A note of caution: Stepfamily structure sets a kind of "compassion trap" for therapists. The heavy load of affect and the couple's seemingly irreconcilable viewpoints can easily draw well-meaning therapists toward one side of a stepcouple. Supporting already fragile stepfamily systems requires therapists to work very hard to hold on to their empathic understanding of all of the players in any dilemma. For the same reason, when more than one therapist is involved with a stepfamily, maintaining regular collegial connection is almost always essential to avoiding these compassion traps.

PSYCHOEDUCATION FOR INSIDER–OUTSIDER CHALLENGES

Several specific psychoeducational interventions can help stepcouples navigate insider–outsider challenges.

- *Name and normalize the pain.* Naming the pain and providing language for "stuck insiders and stuck outsiders" can be incredibly helpful: "It's not because you don't love each other. It's because you live in a structure that makes one of you an insider and one of you an outsider, over and over and over again!"
- *Support all subsystems with one-to-one time.* The phrase "blended family" implies that spending family time together would soften this challenge. Stepfamilies do need to do fun things together and create new rituals to build a new "we." However, insider–outsider positions will be most intense when everyone is together. One of the most helpful, and often least intuitive, strategies for stepcouples is to add lots of "compartmentalizing" to "blending." Carving out time alone for the adult stepcouple, for parent–child relationship(s), and for stepparent–stepchild relationship(s) meets the competing needs of all of the subsystems in a stepfamily.
- *Help stepcouples establish recurring daily (private) intimate routines.* Daily life in a stepfamily erodes couple connection, before it is deeply rooted. Creating recurring routines of connection helps build soothing, secure attachment: a "good morning" kiss before getting out of bed, a loving text during the day, a hug each evening before one or both retires. However, there is an important caveat for stepcouples: Do snuggle, kiss, and hug. However, in stepfamilies, it is important to do so out of children's eyesight. (More about this in the next challenge.)

INTERPERSONAL SKILLS FOR THE INSIDER–OUTSIDER CHALLENGE

For a stepcouple, the binding force of mutual empathy cannot come from parents and stepparents feeling the same way. Rather, connection comes from the insider parent's compassion for the outsider's experience of feeling invisible, and the outsider stepparent's compassion for how torn the parent feels between the needs of the child(ren) and the needs of a new partner. On this level, stepcouples often need help learning how to calm down, hold on to their curiosity, and find some empathy rather than getting mired in conflict. Following are some concrete, teachable skills that I reach for often.

- *Self-regulation.* "Let's all take a breath." The constant attachment breaks in stepcouples easily trigger intense emotional arousal. Many clinicians see self-regulation as a key interpersonal skill. Taking a deep breath is the all-time best tool for this.
- *Tracking physiological arousal levels.* I might say, "Looks like things are getting tense. Did you notice?" If the answer is yes: "Great! What was the clue?" If the answer is no: "Lots of people have trouble with this. How about if I help you start to recognize the cues?"
- *Joining.* I use "joining" to interrupt the "but, but, but" escalation that leaves both members of a stepcouple feeling increasingly alone. I use it often in my office to slow things way down, to provide safety, and to shape an experience of connection and caring in the face of divisive stepfamily challenges. On the surface, joining is quite simple. I put up a "time-out" sign and say something like: "I think both of you are longing to be heard. And neither of you is feeling heard. Am I right?" (I have never had a couple say no to this!)

Continuing, I say: "I have something that I think will help. It's awkward and simple, although it can be surprisingly hard. I'll help. Want to try?" I then invite one person to say, "just a sentence or two—what you most want the other person to get." For example, Anna, the stepparent in the previous example, says, "I feel so invisible when your kids are here." Mike starts to react. I step in and ask him to take a breath: "I know you love Anna. See if you can find the place in your heart where you do understand what she just said. Not what you agree with. Just what you do understand." Mike slows down just a bit. He looks at Anna. "You feel really left out." We wait for a nod from Anna that Mike got it.

Now Mike is invited to add just a sentence or two of his own—"the nub of what you want Anna to get." Mike looks up and says, "It's so hard, Anna. It's so hard because I feel so torn." Now it is Anna's turn. She starts with, "But . . . " I step in and say, "Take a breath, Anna. Find the place where you do understand what Mike just said."

I hold this structure with a firm, compassionate hand. We go back and forth, taking just one or two sentences at a time. I am not looking just for the words, but for a kinesthetic sense that each is beginning to "feel felt" (Siegel, 2012) by the other. "It's a bit like holding a cello note with your partner," I often say. Little by little, each person is helped to settle more deeply into their affective experience and to feel the soothing comfort of the other's understanding.

When this goes well, a resonating channel of understanding and caring begins to open. Now it is important to anchor the experience. I ask, "What's it like, Anna, to feel Mike really getting how lonely you feel when nobody in the family looks at you?" She replies, "Such a relief. So much closer." I say, "Can you tell him? Can you tell him what a difference it makes just to feel his understanding?"

And to Mike, I say, "What's it like, Mike, to hear that your compassion makes such a difference to Anna? Is that a surprise? Is it a surprise to hear that what Anna needs most from you is just your loving understanding?" I warn couples that they may not be able to do this at home yet. However, I want to plant seeds of confidence that this channel of connection between them is here and available.

FAMILY-OF-ORIGIN ISSUES IN THE INSIDER–OUTSIDER CHALLENGE

Nobody likes being left out, day in and day out, up close. However, for a stepparent who played second fiddle to a favored sibling, or who was left unprotected and alone in a scary family, the pain can be agonizing. Likewise, nobody likes feeling torn between loved ones. However, a parent who was an anxious kid in a high-conflict family, or who felt they "could never do it right," may find the stuck insider position especially anxiety-provoking.

It is critically important to begin, always, by legitimizing the very real affective impact of stepfamily structure. Staying "low and slow" (Johnson, 2012), I may say, "Being left out over and over and over is so hard. Nobody would like it. And something about this seems to be just frying your wires, right? Again, nobody would like this. But something is triggering you so much that your wise mind is going offline! Just when you need it most! Can I tell you about Papernow's bruise theory of feelings?"

The Second Challenge: Children Struggle with Losses, Loyalty Binds, and Change

Understanding the Challenge

> "Seeking a therapist for a couple forming a blended family. Each has two adolescents. Kids are resistant, hostile, and splitting. Couple is very motivated as wedding is in three months."

This quotation, taken from a therapist listserv, sets the stage for the second challenge. During a major transition when children especially need attuned, empathic parents, parents in stepfamilies are often out of tune with kids. Stepcouples are excited and eager to move forward. But their children (of all ages) are often facing a complicated set of challenges. Struggling kids are often experienced by the adults as "resistant," "uncooperative," or "manipulative," and by therapists as "splitting." It is sometimes big work to help the adults slow down and empathize with kids.

LOSSES

Qualitative research about children in stepfamilies is saturated with themes of markedly decreased parental closeness and increased parent–child conflict (Cartwright, 2008). A new, loving adult relationship is deeply engrossing for adults. Add that outsider stepparents, especially very jealous ones, crave attention from the parent. Older recouplers are often stunned that their adult children feel just as "left" as their younger counterparts.

LOYALTY BINDS

Stepparents often create loyalty binds for children: "If I care about my stepmom [stepdad], I am disloyal to my mom [dad]." To some extent, these loyalty binds are normal; they appear even in highly collaborative ex-spouse relationships. However, when ex-spouses bad-mouth each other or bicker, they tighten these binds unbearably for children (Braithwaite, Toller, Daas, Durham, & Jones, 2008).

THE PACE OF CHANGE

As the amount and velocity of change go up, children's well-being goes down (Jeynes, 2007). Adults are understandably eager to move forward. However, for many children, adjusting to a stepfamily is more difficult and requires more time than adjusting to parental divorce (Ahrons, 2007).

STEPSIBLING RELATIONSHIPS

Stepsibling relationships are generally less close than biological sibling relationships (Ganong & Coleman, 2017). Be aware that children who spend less time in the household enter as outsiders to an up-and-running family. A child who is a more full-time resident is the stuck insider, asked to share space and attention with an intruder.

AGE, GENDER, AND TIME

Boys and children under 8 years of age seem to have an easier time in stepfamilies than do girls and older children. Early adolescent girls have the hardest time (Jensen & Howard, 2015). The early years are hardest in all stepfamilies. However, once things have stabilized, research finds that children in stepfamilies often do as well as children in first-time families (Ganong & Coleman, 2017).

Children's Struggles Can Intensify the Stepcouple's Insider–Outsider Divide

Struggling children are often not happy to have stepparents. They may treat them with disinterest or even outright rejection. Meanwhile, children continue to need their parents. As a result, at the same moment that parents feel cared about and engaged, stepparents often feel (and are) rejected and alone. Expressions of stepparent discomfort may be met by an oblivious and/or defensive parent.

Helping Stepcouples Work Together to Support Children in Stepfamilies

PSYCHOEDUCATION FOR SUPPORTING CHILDREN

A variety of psychoeducational interventions can help stepcouples collaborate in supporting children:

- *Understand children's losses and loyalty binds.* The therapist can say, "It is so natural to want your children to be as happy as you are. It might be painful. But understanding where your kids are coming from will help you to help them."

- *Teach "both–and," not "either–or."* Even experienced clinicians still advise therapists and stepcouples to focus on the couple relationship: "If the couple is doing well, the children will do well." However, in stepfamilies, very close stepcouple relationships are linked to poorer child outcomes, particularly for preadolescent girls (Hetherington, 1993). Both the stepcouple and parent–child relationships need secure attachment and one-to-one time. Note that this also holds true for later-life recouplers.

- *Keep adult physical affection private.* New couples can be very physically affectionate. Parents may believe this gives their children "a better model of closeness." However, watching Mom or Dad snuggle with a new partner very often intensifies children's sense of loss and tightens their loyalty binds.

- *Attend to the particularly resistant child.* A "particularly resistant" child is likely a struggling child. Help the adults understand the story from the child's point of view. Ask whether that child is especially close to the parent in the other household. Children with more intense loyalty binds and/or more loss and change often need less family time and more time alone with their own parents. Because struggling children so often need a lot of distance from their stepparents, help parents understand that rejected stepparents need extra caring and attention from their partners.

- *"But she's your sister now."* Help stepcouples understand that closeness between stepsiblings is an understandable wish for the adults, but it is often not realistic for kids. "Imagine if you were expected to live with, much less love, someone you didn't choose and maybe don't even like!" Coach adults to expect civility, but not love. Do coach stepcouples to establish a few clear rules for safety and civility. This is not a time to "let the kids work it out." Sometimes providing more separation is the most useful intervention for stepsiblings. *The Stepfamily Handbook* (Bonnell & Papernow, 2019) provides practical, evidence-based guidance for stepcouples on these issues.

INTERPERSONAL SKILLS FOR SUPPORTING CHILDREN

Use "joining" to help parents attune to kids. Parents in stepfamilies often need help providing the empathic, compassionate presence that is so regulating for distressed children. In a mother–son session, 13-year-old Bobby says to his mother, Sarah, “I hate our new house.” Sarah splutters, “But it’s a nice house!” Bobby slumps in sulky silence. I put my hands up to call a time-out. I say to Sarah, “I know you want Bobby to feel better. I think I can help. Can you find the place inside where you *do* understand what Bobby said? Can you tell him what you *do* understand about what this is like for him?” (The final case study at the end of this chapter returns to this family.)

In parent–child work, joining goes primarily in one direction, *from* parents *to* children. Parent–child attachment is forever. Even older adolescents and adult children should not be asked to “return the favor” until parental empathy is firmly established.

FAMILY-OF-ORIGIN WORK FOR SUPPORTING CHILDREN

In a stepfamily, parental attunement requires moving toward the child’s pain. Parents (and stepparents) who had to exile their own vulnerability as children may find this particularly challenging. When parents get stuck trying to “fix” their kids, criticizing them, or withdrawing from them, it is time to begin turning attention inward. (The same is true when a stepparent remains highly reactive to a stepchild’s distancing.) As Sarah tries to respond to her son’s distress, it is clear that despite considerable work on the first two levels, she is continuing to jump into “fix-it” mode, triggering angry sulking from Bobby.

In a session alone with her, I say, “I know you want to help your son. And I know that you are getting that what he needs most is to feel like his mom gets it. But something keeps pulling you right into that ‘fix-it’ part, huh?” Again, it is important to first, always fully validate the pain created by stepfamily dynamics: “No parent wants to see their child hurting”; “And something about this seems especially painful for you”; “What happens inside you . . . ?”; “And then what happens? And then?”

The Third Challenge: Parenting Tasks Divide Parents and Stepparents

Understanding the Challenge

Bobby’s most recent report card had been loaded with C’s. His mother, Sarah, at the urging of her new husband, Ben, had agreed to a rule of “no recreational technology” until homework was completed. Ben had caught Bobby texting his friends. Furious, Ben had called him “lazy and irresponsible” and had taken his cell phone away for a month.

Sarah had returned from working out to find her son fuming and crying. She had comforted him and then stayed up late helping him complete his homework. She had also totally removed the consequence. A tense conversation followed between mom and stepdad:

BEN: Bobby broke the rule.

SARAH: He’s 12. Twelve-year-olds break rules.

BEN: He needed to be punished.

SARAH: You went way overboard! That was an outrageous thing to do to an adolescent.

BEN: You cave the minute he gets upset! No wonder he’s lazy and irresponsible!

SARAH: Why do you always overreact?

Sarah and Ben are struggling mightily with the third challenge. Parenting tasks are dividing them. The chart in Figure 22.1 describes parenting from “warm” to “cold,” and from “firm” to “permissive,” creating four parenting styles. The challenge is that stepparents and parents are pulled to opposite corners. A large body of research indicates that children in all family forms do best when parents practice *authoritative* parenting—the upper left corner of Figure 22.1 (Darling, 2013). However, stepparents, as we see with Ben, are pulled toward the upper right, *authoritarian* (harsh and firm) quadrant. Parents, as we see with Sarah, are pulled toward the lower left, *permissive* (loving but not firm enough) quadrant of parenting. What the parent sees as normal adolescent behavior, the stepparent sees as “lazy and irresponsible.” What Ben sees as appropriate discipline, Sarah sees as way too harsh. Furthermore, parents’ deeper emotional connection with their children makes compassion easier to access when their children misbehave. Add to this that struggling stepchildren can be distant and even rude to their stepparents, making distasteful behavior that much more irritating.

Children are often a primary area of disagreement in stepcouples. When this goes poorly, stepcouples get caught in escalating cycles of a “polarization polka,” each pulling further into opposite corners. Meanwhile, neither harshness nor permissiveness meets children’s need for authoritative parenting. When this goes well, stepparents help parents pull “up” toward firmer parenting, and parents help stepparents pull “over” toward more warmth and empathy. Stepcouples work together in a kind of “collaborative

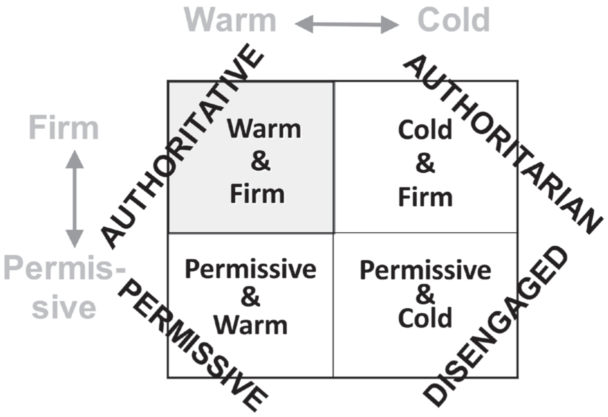


FIGURE 22.1. Parenting styles. From Bonnell and Papernow (2019, p. 191). Reprinted with permission.

cha-cha," talking constructively about their differences.

Best Practices for Meeting the Parenting Challenge

PSYCHOEDUCATION FOR THE PARENTING CHALLENGE

Forty years of research and clinical practice provide some clear guidelines for meeting stepcouple parenting challenges.

- *Use the parenting styles chart.* I keep the parenting styles chart visible in my office. I use it to begin teaching the research about "good parenting" and to help stepcouples visualize and track their polarizing cycles.
- *Coach parents to retain the disciplinary role.* The research is clear: Until or unless stepparents have established a caring, trusting relationship with a stepchild, parents must retain the active disciplinary role (Ganong & Coleman, 2017). Even authoritative parenting by a stepparent, too early, can backfire. A helpful guideline for stepparents is "connection before correction."
- *Stepparents have input; parents have final say.* Stepparents do need to have a say in parenting decisions. Again, they can often help parents to firm up a bit. However, stepparents function best as "sounding boards, not saviors."
- *Authoritarian parenting by stepparents is toxic to stepparent–stepchild relationships.* This assertion is true even in many cultures that value authoritarian parenting (Ganong & Coleman, 2017). Unfortunately, stepfamily structure pulls stepparents to this corner.
- *When the parent is absent.* When Sarah is leaving the house, she can say to her son, "Ben is in charge. The rule is no social media before homework. I expect a good report from Ben!" If Ben catches his stepson texting, he can say, calmly, "You know the rule! No texting before homework! I'd like to give your mom a good report." Ben then reports to Sarah. Sarah (not Ben) follows through with consequences.
- *Children in the same family may respond very differently.* Young children (age 8 and under) are often more available than older kids to a relationship with a new stepparent. Children with lots of losses and intense loyalty binds may need much more parent–child time and less "family" time.
- *Stepparenting over time.* Stepparents who have forged a caring, trusting relationship can move slowly into an authoritative parenting role. "Slowly" often means over at least a couple of years. In many healthy stepfamilies, especially those that began with older children, stepparents do not ever move into a disciplinary role.

INTERPERSONAL SKILLS FOR THE PARENTING CHALLENGE

Feelings run high on these parenting issues. The pull toward polarization can be powerful and extremely destructive. In addition to accurate information about what works, good interpersonal skills are key to engaging constructively over parenting differences. I use "joining" to help stepcouples slow down and begin to hear each other (see Insider–Outsider challenge). Following are two more concrete tools that can be very helpful.

- *Help stepcouples to recognize their "polarization polkas."* The goal is to help couples begin to see their polarized cycles rather than each other, as the enemy.
- *Use "soft–hard–soft" to bring up difficult issues.* "Soft–hard–soft" is a simple, concrete tool that offers ways to bring up hard things while still pulling each other close. Couples who cannot do "joining" at home can do "soft–hard–soft." "Soft" can be an expression of caring, expressing understanding, owning your part, giving positive feedback, or acknowledging positive intentions. The directions are: "See if you can find a few softs. When you've found some, notice what happens in your heart." Then, "Try starting with a couple of softs." Then, "Now try saying the 'hard' thing, but with that same soft energy." Finally, "Now add another soft." I describe this to my clients as a kind of "reverse Oreo cookie." Sarah might have said to Ben, "I get that you were upset. But, Honey, I need to ask you not to yell at him or call him names. I get that I let him off a bit too easy." Ben might have initiated, saying, "You're right. Maybe a month was too long. I do think Bobby needs more follow-through on the rules. Can we talk about that together?" Either of these moves might have had a decidedly higher probability of beginning a collaborative conversation about setting realistic limits for Bobby.

FAMILY-OF-ORIGIN ISSUES TRIGGERED BY THE PARENTING CHALLENGE

When either stepparents or parents cannot seem to move out of a "wrong" corner of the parenting chart, I begin asking, "What was parenting like in the family you came from?" Sometimes just raising awareness of the past's contribution to the present enables parents or stepparents to shift into new behavior. When things stay "stuck," however, old family-of-origin wounds may need healing before further progress is possible.

Issues for Stepparents. No stepparent enjoys a stepchild's irritating behavior. However, stepparents who grew up with authoritarian parenting have a double pull toward that upper right corner: both stepfamily structure and deep-seated beliefs about "how parents act." These stepparents may also confuse the empathic warmth of authoritative parenting with "weakness." Stepparents who had to shut down their own need to protest in order to maintain safety with an authoritarian parent may find their stepchildren's "back talk" especially triggering.

Issues for Parents. Parents raised with either authoritarian or permissive parenting may confuse a stepparent's request for calm, caring firmness with "being mean." For a parent with a history of parental abuse, a stepparent's harsh parenting behavior may trigger reactive hysteria or numb collapse rather than the constructive engagement needed to protect children.

The Fourth Challenge: Stepcouples Must Build a New Family Culture While Respecting Already Established Cultures

Understanding the Challenge

Stepfamilies face constant differences over everything from the definition of an "expensive" pair of sneakers to the details of holiday rituals. What feels like "home" to one part of the family may range from uncomfortable to deeply upsetting to the other. Furthermore, an entire parent–child team often weighs in on one side of every difference. Some of these issues can be anticipated by talking about money, bedtimes, discipline, and other important issues before stepfamily members begin living together. However, a substantial portion of any group's most central operating assumptions lie out of awareness until someone violates an expectation. In a stepfamily, this often happens in the midst of ordinary family activities that everyone presumed would be uneventful or even comforting: cleaning up after dinner, decorating the Christmas tree, buying a gift. The spike of distress easily registers as an attachment break.

Meeting the Challenge

To meet this challenge, stepcouples must find a way to bring some measure of self-soothing and curiosity to these moments of culture shock, perhaps even some humor. Stepcouples are often advised to immediately create a list of familywide shared rules, and parents are urged to "back up" stepparents. Although this makes some logical sense, it creates too much change too fast for kids, and it prematurely pulls stepparents into a disciplinary role.

PSYCHOEDUCATION FOR DEALING WITH DIFFERENCES

The following guidelines can help stepcouples work toward building a new family culture.

- *Normalize the intensity.* Gentle empathic humor can be very helpful: "Amazing, isn't it, that you are suddenly in World War III over what to do with wet towels!"

- *Change the metaphor.* Becoming a stepfamily is less like blending blueberries and strawberries into a smoothie, and more like bringing together a Japanese family with an Italian family. It will take time to learn about each other! Requiring everyone to eat pasta and use chopsticks will only make misery.

- *Expect surprises.* We can help stepfamilies expect a lot of "learning by goofing," which can help stepfamily members to take a breath and respond with, "Oops! Another one. Help me understand what happened here!"

- *Maintain familiar routines and objects that support children's comfort and security.* It is especially important to maintain the structure of bedtimes, mealtimes, morning routines, and so on. This is not, in fact, a good time for brand-new everything. When possible, encourage parents to hold on to some familiar things such as furniture and pictures.

- *Make changes a step at a time.* Successful stepcouples bear the discomfort of their differences while they build enough mutual understanding to forge resolutions that best meet the needs of all concerned. In double families, making gradual changes may mean having two sets of rules for a while. Giving children input can substantially increase their buy-in. "Let's all think about a couple of rules that would make this family better for everyone." Start with a few shared rules that ensure safety and civility.

- *Equalize the amount of change.* Knocking first or asking before borrowing may be second nature to Eric but brand new to his stepbrother Tommy. For Tommy this will require much more effort and lots of calm reminding. When possible, equalize demands for change.

- *Honor differences.* Just as many of the differences between a group of Japanese and a group of Italians will remain in place, healthy thriving stepfamilies often keep many of their differences, right alongside their new shared rituals and habits and values.

INTERPERSONAL SKILLS FOR LIVING WELL WITH DIFFERENCES

Following are a few concrete tools that help stepcouples to meet this challenge.

- *Take a breath and track arousal levels.* (See Insider–Outsider challenge.)

- *Make requests, not criticisms.* I find that sentence stems can be very helpful: "I'd love it if you'd . . . [ask your kids to wash the dishes/speak more kindly to my son, etc.]" or "Would you be willing to . . . [talk about some firmer limits for Bobby]?"

- *Use "soft–hard–soft."* For example: "I know your kids are used to leaving their dishes in the sink. It's driving me nuts. Can we work on this together?" not "Your kids are slobs."

- *Help stepcouples lead with curiosity.* For example: "Tell me more about how you guys think about [doors, noise/presents/the cost of a pair of sneakers, etc.]" not "How *could* you . . . !"

FAMILY-OF-ORIGIN ISSUES IN DEALING WITH DIFFERENCES

When expectations are broken, and intimate others "don't get it," the sense of alarm and aloneness can be intense. Rude surprises are much more provocative for those who grew up in an abusive or chaotic family, where unpredictability was terrifying. Likewise, constant glitches are much more triggering for those with a history of insecure attachment. If reactivity persists, healing old bruises may free resources to meet the challenge.

The Fifth Challenge: Ex-Spouses Are Part of the Family

Understanding the Challenge

Children in stepfamilies almost always have another parent outside of the family—dead or alive, present or absent—who can affect everything from the child's openness to their stepparent, to family finances, to holiday planning. Several decades of family scholarship have unequivocally established the deleterious effects of conflict on children (Reynolds, Houlston, Coleman, & Harold, 2014). The primary determinant of poor outcomes for children is not family structure (divorce, single-parent families, or stepfamilies). It is family process: exposure to conflict, along with compromised parenting (Dunn, 2002). In fact, young adult and adult children with long-divorced, low-conflict parents exhibit significantly better well-being than those (especially women) of never-divorced, high-conflict parents (Amato & Afifi, 2006). Even moderate tension in nonclinical, never-divorced families negatively impacts children's sleep, which in turn compromises their academic achievement, attention, and immune systems (El-Sheikh, Buckhalt, Cummings, & Keller, 2007).

Meeting the Challenge of Co-Parenting across Households

PSYCHOEDUCATION FOR THE CO-PARENTING CHALLENGE

The following guidelines can facilitate better co-parenting across households:

- *Collaborative, low-conflict ex-spouse relationships are best for children.* Collaborative divorced parents work together to meet children's needs. In my experience, putting children's needs ahead of ex-spouse conflict is just beginning to take root in the United States.
- *Low-conflict "parallel parenting."* Low-conflict "parallel parenting" is next best for children and is more common. It works well enough for children, especially when one or both parents provide authoritative parenting (White & Gilbreth, 2001) and neither parent exerts coercive control over the other. In my experience, children can manage very different rules and routines in their two houses if parents are respectful: "In Mom's house, you can have sugar cereal for breakfast. In Dad's house, we eat whole-grain cereal. When you grow up, you can decide which you think is best."
- *Teach the research.* Remind parents that children fare best when they have positive, close relationships with both sets of parents and stepparents (King, 2009; White & Gilbreth, 2001).
- *Promote predictable and consistent parenting plans.* Such plans are linked to better outcomes for children. For school-age children, consistency in weekday scheduling is especially important. Weekends are less critical (Pruett, Ebling, & Insabella, 2004).
- *Nonresidential father–child relationships.* These relationships are vulnerable in divorce and recoupling, particularly father–daughter relationships (King, 2009). Fathers often need extra support to keep reaching out. Stepparents can be an important source of support and encouragement: "How about taking your daughter out to lunch?" or "If she won't answer a phone call, then text her!"
- *Attachment is hardwired.* Adults are often eager to be free of abusive or inadequate ex-partners. Children need adults to understand that their relief at less contact with that parent is very often mixed with grief and confusion.

INTERPERSONAL SKILLS TO MEET THE EX-SPOUSE CHALLENGE

The toxic impact of parental conflict on children is clearly established. Clinicians need to monitor, educate parents about, and intervene in postdivorce conflict with the same attention that physicians pay to managing adult blood pressure. Therapists must proactively help ex-spouses to use their very best skills with each other, in situations that often pull for their worst. Parents (and stepparents) often need some coaching to meet this challenge. I teach my clients to use "joining" ("Stop, take a breath, and say what you *do* understand first") and "soft–hard–soft" with ex-spouses. I also help my clients learn to write short, factual, nontriggering responses to provocative communication (Eddy, Burns, & Chafin [2014] and Wittman [2001] are excellent resources).

FAMILY-OF-ORIGIN ISSUES IN EX-SPOUSE RELATIONSHIPS

Even very senior couple therapists are vulnerable to allying against the "bad behavior" of an ex-spouse, without looking at the contribution of their own client's reactivity. Very volatile or "irresponsible" ex-spouses require especially wise, strategic responses. However, a dad with his own childhood history of abandonment or abuse may be so triggered by his ex-wife's poor parenting that he either flails helplessly at her or freezes. Therapists can begin asking right away, "What happens inside when . . . ?" Provide psychoeducation about protecting children from conflict and teach skills for handling a high-conflict ex-spouse (Eddy, 2014; Wittman, 2001). If reactivity persists, healing old wounds can increase capacity for effective engagement.

ADDITIONAL GENERAL PRINCIPLES AND TECHNICAL ASPECTS

Becoming a Stepfamily Is a Process, Not an Event

An early task is helping stepcouples absorb that becoming a stepfamily takes time, lots of it. Even stepfamilies that move most quickly may take a couple of years to feel some stability and ease. A substantial sense of "we-ness" usually requires another couple of years. Faster families tend to begin with more realistic expectations, get some good evidence-based guidance early on, and/or learn quickly from experience. Faster families also tend to bring better interpersonal skills. They bring fewer family-of-origin bruises or they fully commit themselves to their own healing. On the other end of the spectrum are stepcouples with entrenched fantasies of "blending," very poor interpersonal skills, and/or deep, old bruises triggered by stepfamily challenges. An extremely jealous, "bad-mouthing" ex-spouse can make moving toward stepparents almost impossible for children.

Work in Subsystems

This chapter focuses on therapy with stepcouples. However, stepcouples are embedded in complex interlocking systems with competing attachment needs that make meeting with a whole stepfamily more destructive than helpful. It is critical for therapists to keep the whole system in their minds and hearts, but to work in subsystems (Browning & Artfelt, 2012). Often the focus is couples work in parallel with parent–child work (and sometimes work with siblings or stepsibs). Once a compassionate secure connection is more established in these two systems, work with the whole family is more possible. Early work with the stepparent–stepchild relationship focuses on low-key friendship building. I generally do not see stepparents and stepchildren together until stepparents can fully hear their stepchildren's pain.

Who you see in therapy depends somewhat on your particular skill set. My own training is in both systems and individual trauma work. As we move into the intrapsychic level, I may work individually with one member of the couple in front of the other, carefully contracting for safety both in my office and after the couple leaves the session. If conflict is high, and safety is low in the couple, I am comfortable interspersing individual sessions with couple work. Other clinicians may prefer to refer for individual therapy. If conflict is high, meeting with ex-spouses is also key. (If this is not your forte, develop a trusted cadre of mediators and postdivorce co-parenting coaches.)

A caveat: The intensity and pain in stepfamilies pull therapists to ally with their own client(s). Again, if more than one therapist is involved, maintaining regular collegial contact is critical.

Getting Started with Stepcouples

I begin by asking each member of a stepcouple, "What would you each like help with? Is there anything you *don't* want to have happen here?" The answers to these questions help to focus our work. They also provide a contract for intervention, enabling me to say, "I'm going to step in here! You both said you didn't want to fight. Let's take a breath and try something different."

Even more than most, stepcouples arrive for couple therapy feeling inadequate, overwhelmed, frightened, and embarrassed. I look for every bit of evidence about what a stepcouple is doing well, even if it is, "I can see you guys really care about each other."

Assessment in Stepcouple Work

With Which Challenges Is This Couple Struggling?

Begin where the couple is, with the challenge that is giving them the most trouble. When in doubt, the insider–outsider challenge is often the first that needs to be addressed. It is a core challenge for stepcouples. It comes early, stays late, and threads its way through the other challenges. Challenges related to parenting children often come in a close second. When adults are your clients, look for children's challenges hidden in complaints about "resistant" or "manipulative" stepchildren.

When a child is the referred client, couples work is often key to helping kids. Look for losses (is there enough parent–child alone time), help adults acknowledge and, if possible, loosen loyalty binds. When a child is struggling, stepcouples often need to slow the pace of change, increase parent–child one-to-one time, decrease demands to "be part of the family," and move stepparents out of discipline.

Construct a Genogram

I begin constructing a genogram with my first contact and fill it in as we go, noting which relationships are going well and where the difficulties lie. In early sessions, I focus on the present: "Who is in your family?" "Who is with you when . . . ?" I ask for a few descriptive words about each child. I inquire about ex-spouses and listen carefully for levels of ex-spouse conflict and collaboration. In the second or third session, I may begin filling in the past: "Who was in the family you came from?" I ask about siblings, family interaction, and attachment: "Who did you go to if you were sad or scared?" I store this information until intrapsychic work is appropriate. Over time, I begin exploring intergenerational patterns and burdens.

Begin with Psychoeducation and Interpersonal Skills

Again, naming painful insider–outsider positions, encouraging one-to-one time, deepening empathic attunement with kids, and easing stepparents out of discipline are often early and vital pieces of psychoeducation.

Learning that you've been "doing it wrong" is always potentially shaming. Throughout clinical work with stepcouples, I discipline myself to begin any "correction" with an empathic "joining" statement about what I do understand. For instance, I may say to a stepparent like Ben, "It makes total sense that, as an adult, you would expect to be a disciplinarian." When I offer a new piece of psychoeducation, I always ask, "What's this like to hear from me?" If you get "resistance," slow down. Take a breath. The "language of wishing" can help access the grief that often lies under apparent resistance: "You so wish you could just step in and set this kid right."

On the interpersonal level, can this couple talk about their struggles with kindness and caring? How do they handle differences—with respect and curiosity, or with criticism and withdrawal? Can they soothe themselves and reach for each other when there are glitches?

I do begin asking right away, "What happens inside when [your husband focuses entirely on his son/your wife tells you that she feels abandoned, etc.]?" This question lays the groundwork for the fact that external events evoke internal responses that can play a big part in how things unfold. Early on, however, I make an empathic connection, then move into one of the first two levels—providing psychoeducation or fostering interpersonal connections ("Yes, living with a child who doesn't speak to you can be so painful! It turns out that we know something about what's happening here. Want to hear?" or "Can I help you talk about this together in a way that pulls you closer to each other?").

When to Begin Turning Inside

The intensity of stepcouple distress can lead individually trained therapists to begin their work on this level. However, beginning here is disrespectful of the fact that daily living in a stepfamily can make the sanest of us look and feel crazy. I always start with the first two levels. But, if information doesn't stick and skills don't hold, it is time to turn attention from very real outside events to the old wounds they may be activating. The clue to shift levels is often a sense of "looping, looping, looping" or "we've been over this before."

I have been storing away clues to family-of-origin dynamics that may be in play. I may have noted on my genogram that a parent with a big "fix-it" part had a very depressed mother, or that a stepparent with big feelings about their outsider status had an older brother who got all the attention. When reactivity continues to be high (or low) despite psychoeducation and building connection, I do always begin by fully validating stepfamily dynamics ("It is so painful when people up close turn away from you"). Now I follow with "And it looks like something is frying your wires!" or "Can I tell you about 'Papernow's bruise theory of feelings' "?

My toughest cases involve a stepmother with deep family-of-origin wounds about being left unprotected or invisible, partnered with a parent who grew up subjected to intense criticism and/or abject alone-ness. Stepfamily challenges unleash a torrent of agonized rage from the stepmother, evoking terrified withdrawal in her partner. These couples get stuck in intense cycles of Stepmom's pained rage and Dad's overwhelmed withdrawal. Forward movement can often require several years of both intensive couple work and significant individual trauma work.

Intensity and Frequency of Treatment

Work with stepcouples varies tremendously. A few psychoeducational meetings that provide a map and some driving directions enable some stepcouples to move forward. As one stepdad said to me, "I just needed a guide in the wilderness." For other couples, the work can extend over several years, moving among all three levels.

Therapy may involve weekly meetings with one or both members of the couple, as well as collateral work with children, ex-spouses, and in-laws. One person may choose to do an extended piece of individual work, with or without the other partner. We may go for periods of time where we meet less often or not at all, then convene again when external or internal events reintensify the challenges. Each cycle of work may last a few sessions, a few months, or several years.

INTERSECTIONALITIES WITH STEPFAMILY CHALLENGES

Although the research still focuses on Anglo-American stepfamilies headed by mixed-gender married couples with children under 18, families all over the world, including stepfamilies, are increasingly diverse and complex (Sassler & Lichter, 2020). Stepfamily structure creates the five challenges described here across populations. However, intersectionalities with ethnicity, cultural values, legal systems, life stage, and minority status can soften or intensify those challenges. This section describes what we know about the challenges for LGBTQ stepcouples, African American and Latinx stepfamilies, and later-life recouplers.

LGBTQ Stepcouples

Because the average age of coming out has dropped from 37 to 17 in the last four decades (Family Equality Council, 2019), the percentage of LGBTQ couples in first-partner families will increase in the next few years. Currently, however, although it is rarely acknowledged, the majority of LGBTQ-headed families are stepfamilies. LGBTQ stepcouples face challenges very similar to those of their mixed-gender counterparts, with some extra themes and variations, as well as some special strengths that may come from living outside heteronormativity. It is stigma, not sexual preference or gender identity, that intensifies some of the challenges.

Dashed expectations of "blending" and the experience of insiderness and outsiderness in LGBTQ stepcouples echo those in other stepcouples, sometimes with extra layers. A trans stepmom said to me, "There is already so much about how 'different' we are. I just want us to be a family. Like any other family." Differences in "outness" can intensify outsiderness for stepparents. Jenny, mom of two children from a lesbian relationship, came out as an adolescent. She now has a strong gay-affirming network of family, friends, and coworkers. Her partner, Dora, came out only recently. Dora, mom of a son, remains closeted at work and with most of her very conservative family, leaving her with nobody to reach for when Jenny turns to her kids.

Children in stepfamilies headed by LGBTQ stepcouples speak about the same losses and loyalty binds that other kids do. Currently, children of LGBTQ stepcouples often begin their lives in a family headed by a mixed-gender couple. However, research suggests that adjustment to a conflicted divorce and/or to a stepfamily is actually more challenging than coming to terms with changes in their parents' sexual preference or gender (Titlestad & Pooley, 2014). Most challenging for kids is living in a homophobic heterosexist culture that exposes them to bullying (van Gelderen, Gartrell, Bos, van Rooij, & Hermanns, 2012), homophobic slurs, and heterosexist school and church teachings (Kosciw & Diaz, 2008). Despite the burden of stigma, many child outcomes for children in gay- and lesbian-headed stepfamilies are slightly better than those headed by mixed-gender stepcouples (van Eeden-Moorefield & Pasley, 2013).

Parenting challenges in LGBTQ stepcouples are also very familiar: Stepparents want more firmness and control, and they may occasionally step in too harshly. Parents want more care and acceptance for their children, and they may struggle with limit setting. However, gay and lesbian stepcouples appear less likely to have stepparents move prematurely into a disciplinary role (van Eeden-Moorefield, 2013), and children of gay male stepcouples also appear to complain less often about intrusive parenting by their stepfathers (Crosbie-Burnett & Helmbrecht, 1993). Lesbian stepcouples also expose children to lower levels of conflict (van Eeden-Moorefield, 2013), which we know is key to well-being.

In terms of ex-spouse challenges, divorce for LGBTQ parents remains a legal minefield, which in turn impacts stepfamily well-being. LGBTQ parents, especially trans parents, still lose their children to straight parents. Property division for the lower-earning partner in a decades-long LGBTQ relationship may be determined by "marriage length," even though gay marriage was only legalized in 2015 (Kim & Stein, 2018).

Work with LGBTQ stepcouples proceeds as it does with all other stepcouples, with some critical additions (Papernow, 2021). Differences in "outness" and living in the context of stigma often need to be part of the conversation. Engage LGBTQ stepcouples about, and give kids a say in, how the family makes decisions about openness—when and how much to include stepparents in school and athletic events and children's birthday parties, how much "outness" to display to children's friends. LGBTQ stepfamilies often experience less family support than their heterosexual counterparts. Developing a "chosen family" is important to both adults and kids. With the current threats to the newly won protection of LGBTQ marriage, encouraging stepcouples to execute wills, health care proxies, and so forth, is important to support family health and stability.

When humiliation and rejection have been part of growing up, stepchildren's rebuffs may be especially painful for stepparents. Likewise, a family history of parental rejection may unbearably amplify the anxiety of the stuck insider position. Concurrent trauma treatment can support stepfamily development. When shame is so much part of the story, it is especially critical to begin any invitation to turn inside by acknowledging and validating the very real power of stepfamily dynamics: “Nobody would like this one bit. And it looks like your wise mind is going offline! How about we pay attention to what happens inside when . . . ?”

African American Stepfamilies

The percentage of stepfamilies among African Americans is considerably higher than in other racial groups. However, African American cultural values offer some special strengths for stepfamilies. African American adolescent stepchildren in several large samples show significantly more positive outcomes than European American stepchildren do (Adler-Baeder et al., 2010). African American traditions of “child keeping” and “informal adoption” provide support for child-caring across family lines (Stewart, 2007), which may ease ex-spouse tension and contribute to better outcomes. This value on cross-household parenting may also be linked to findings of strong co-parenting relationships, even among some never-married, never-cohabiting parents (McHale, Waller, & Pearson, 2012). African American stepfathers are more likely than their Anglo counterparts to support their partner’s parenting rather than stepping into a disciplinary role (Stewart, 2007). Most striking, across a variety of measures, African American nonresidential fathers, both formerly married and never married, maintain much higher levels of ongoing involvement with their children than either Anglo American or Latino dads do (Stykes, 2012).

African American stepcouples are more likely to be unmarried and cohabiting, often with children from multiple partners. Cohabiting couples sometimes establish long-term relationships and stable families. However, these unmarried parents are much more likely to form “fragile families” that are generally younger, experience more household transitions, and tend to come from populations that experience more poverty, less education, and higher rates of depression and anxiety than do married co-parents (McHale et al., 2012).

All of these realities mean that effective clinical work with stepcouples in African American stepfamilies sometimes involves an extended network of co-parenting adults. This was the case for Darnell’s family. Eight-year-old Darnell was referred to a local clinic for fighting and skipping school. Darnell’s mom and dad had parted when he was 5. Darnell lived mostly with his mother, Nia (24); her boyfriend, Tyrone (26); their new baby; and occasionally Tyrone’s two children. Darnell also spent time with his dad, his grandmother, and several neighbors.

The caseworker began by convening “Darnell’s team,” including Darnell’s grandmother, two of the neighbors, his father, his mother, Tyrone, and Darnell. The caseworker helped the team to express their concern for Darnell, who in turn divulged that he hated sharing his mom with Tyrone and his children. A neighbor offered to care for Nia’s baby to free up some regular mother–son playtime. Concurrently, the clinician met with the mom and her son, focusing on strengthening their relationship. He also worked to stabilize Nia and Tyrone’s relationship, honing their communication skills and helping them work together to be better parents to their own children. He applauded Tyrone’s support of Nia’s primary disciplinary role with Darnell. The caseworker also met with Darnell’s parents together, actively appreciating their very cooperative co-parenting, and working on Mom’s limit-setting skills with Darnell.

Latinx Stepfamilies

The Latinx community comprises a diverse group from about 23 different countries. Nonetheless, Latinx stepfamilies share some commonalities that shape stepfamily processes and inform clinical work. Latinx stepcouples are more likely to be poor and to be cohabiting and unmarried (Donahue, Garfinkel, Haskins, McLanahan, & Mincy, 2010), with the vulnerabilities discussed earlier for African American fragile families.

Latino nonresidential fathers are more likely to be “exiled” from the new stepfamily, leaving children with unvoiced losses. Although Latinx adults are more likely to treat stepfathers as fathers, researchers found that, when alone, children spoke longingly about their dads (Adler-Baeder & Schramm, 2006). For undocumented stepfathers, the current U.S. political climate can painfully intensify the isolation of their outsider position.

Clashes between American and Latinx value systems may interact with parenting challenges: A Latino stepfather may be especially alarmed by his Americanized adolescent stepchildren’s lack of *respeto*, while his Americanized stepchildren and their second- or third-generation mom see a certain amount of back talk as “normal.”

There is no word for “stepfamily” in the Spanish language. Latinx stepfamilies often identify as “regular families” (Adler-Baeder & Schramm, 2006), with stepparents listed as parents on school records. Thus, “strengthening the family” is likely to be more engaging than “learning about being a stepfamily.”

Latinx cultures value close family ties and cooperation over individualism (Falicov, 2013). The Western clinical bias toward expressing individual needs (“I feel,” “I want”) runs counter to these values. Therapy is framed in the service of “making the family closer” rather than of enhancing individual well-being. Work with Latinx stepcouples may sometimes need to proceed without using the words “stepfamily” or “stepparent”: To a stepfather who left his parents and siblings behind in Guatemala, a social worker talks about being a “double outsider.” She describes his wife, a third-generation Latina surrounded by her family, as “an insider several times over.” Recommending one-to-one time, a guidance counselor speaks in the third person, using no “step” words: “When there are lots of changes in a family, it makes the family stronger when kids have time alone with their moms and the new people have time alone together to get to know each other.”

Older Recouplers

Although divorce rates in the United States are at a 40-year low, rates for those over age 55 doubled between 1990 and 2010 (Brown & Lin, 2012), with a concomitant rise in older recouplers. Add to this that Americans age 65 and older are the fastest growing segment of the U.S. population (U.S. Census Bureau, 2014). Note that “gray recouplers” may not be living together. They are three times more likely to be “living apart together” (LAT) in a committed relationship (de Jong Giervald, 2004). (LAT can also be a good solution for younger stepcouples with especially vulnerable children.) “Gray recouplers” now form a substantial portion of stepfamily referrals.

Later-life recouplers find themselves facing challenges similar to those of their younger counterparts, with some additions due to the later life stage. Like younger stepcouples, gray recouplers often need help grieving their fantasies of “blending.” A dad loves having his adult kids and grandkids over. His new partner finds their presence intrusive and burdensome. Especially surprising to older recouplers, adult children, just like their younger counterparts, often experience new partners as intruders. Sixty-three-year-old Sheila happily brings her new love to her son’s 40th birthday party. She is stunned at her son’s upset. “Why aren’t they happy for me?” is a frequent refrain. “I’ve got an answer for you,” I respond. “Want to hear?”

Father–daughter relationships are often a focus of difficulty (Papernow, 2018). I have had dozens of consultations in which an older dad’s expectation that his adult daughter would embrace his new relationship unleashed years of the daughter’s unvoiced pain and abandonment. In these families, reparative father–daughter work must precede any openness to Dad’s new relationship. The stepcouple often needs help processing this together. The new partner often needs help focusing on reaching out to her sweetie (“I’d like a hug”) rather than insisting, “Dad, make your daughter accept me.” Dad may need help setting boundaries: “I can hold you (new partner) and comfort you. I cannot, and will not, cut off my daughter to prove my love for you.”

That said, new partners can also have profoundly transformative effects on strained father adult–child relationships: A previously distant, irascible dad finds an engaging, warm new partner who encourages him to reach out more persistently to his children and grandchildren, and coaches him to be less critical and controlling.

Parenting challenges also abound in these later-life recouplers. Parenting differences often focus on “appropriate” levels of financial, physical, and emotional support for adult children. Parents want to help their kids; stepparents see this as “infantilizing” or “enabling.” Add to this that young adults are much more likely to be living at home than they were a few decades ago, due in part to crushing student debt and the higher costs of housing (Payne, 2011). In regard to cultural challenges, each member of an older stepcouple brings daily habits ingrained over many decades. Celebratory rituals and family values are embedded in complex systems of adult children, grandchildren, and friendships, intertwined with a decades-long marriage.

An “easy wrong turn”: Family therapists all too often make the mistake of privileging the older stepcouple’s relationship as more “primary” than the parent–child relationship: “Your daughter needs to get that this new couple is the reality now.” However, “reality” includes both decades-long parent–child relationships and the new stepcouple relationship. Like their younger counterparts, therapists can often help older stepcouples carve out one-to-one time that supports all relationships and they can urge parents to remain in charge of setting limits with their own children.

Older stepfamilies are more likely than first-time families to need help negotiating how, where, and by whom an ill partner will be cared for and estate division among children of parents and stepparents (Zietlow & Cahn, 2017). When one member of a stepcouple dies, lack of shared history can trigger highly emotional flare-ups between adult stepsiblings over seemingly "small items": "What! You gave away that plate! That's the one Mom gave me when I graduated." As with younger stepfamilies, begin by meeting in subsystems rather than with the whole family.

EMPIRICAL SUPPORT

The research on stepfamilies has expanded exponentially over the last four decades. The field began with "deficit comparison" (Ganong & Coleman, 2017) studies that compared outcomes for children in stepfamilies to children in first-time families. It has moved to more strengths-based explorations of processes within stepfamilies that differentiate healthy stepfamilies from struggling stepfamilies, using increasingly sophisticated qualitative (e.g., Ganong & Coleman's work, and the work of Dawn Braithwaite and her colleagues [2008]) and quantitative (e.g., Todd Jensen's work, including Jensen & Howard, 2015) methodologies.

In terms of intervention, Smart Steps is an evidence-based, six-session, extremely well-designed group psychoeducation and skills-building program targeted specifically for stepfamilies (see "Suggestions for Further Study"). The effectiveness of Smart Steps has been empirically validated with couples of varied distress levels, diverse socioeconomic backgrounds, and different ethnicities.

However, empirical exploration of therapy with couples in stepfamilies has remained almost nonexistent. In one 1996 study, Pasley, Rhoden, Visher, and Visher found, not surprisingly, that stepcouples most needed help with parenting/stepparenting issues and were most frustrated when therapists lacked sufficient stepfamily training. No other studies have looked at process or outcomes of therapy with stepcouples. More broadly, only two clinical books have been published in the past three decades about working with stepfamily couples (Browning & Artfelt, 2012; Papernow, 2013). Even more concerning, clinical training in effective therapy with these couples remains virtually nonexistent.

CASE ILLUSTRATION

For some stepcouples, a few sessions of psychoeducation, combined with a bit of coaching around interpersonal skills, puts them on track to meeting their challenges. Ben and Sarah, who have appeared several times in this chapter, were on the other end of the spectrum. They needed considerable help on all three levels, stretching over several years.

Ben was the divorced father of 4-year-old Judy and 6-year-old Jimmy. Sarah was the widowed mother of 13-year-old Bobby. The couple had been coworkers before Sarah's husband had died of COVID-19, and Ben had been a "huge comfort" to Sarah. The relationship had quickly deepened. They had moved in together, excited to combine their resources in a new family. Ben's children were doing well.

"The problem is Bobby," Ben said, launching into a bitter recitation of his stepson's "inexcusable" behavior. "He's rude and manipulative. He barely says hello to my kids. He locks himself in his room. He ignores even my most basic request to set the table." Sarah sat silent and tight-lipped. "He has been through a lot," she offered weakly. Ben replied tersely, "We've given him a beautiful new family. Besides, my kids are okay. What's his problem?"

When I asked for more background, it became clear that, within a short time, Bobby had lost every secure attachment in his life. He had lost his father. Then soon afterward he had lost his mother to an intense new love. He had started in a new school with no friends and much tougher academic standards. Two much younger stepsiblings had joined the family and now competed for attention.

As Bobby's distress became palpable to me, I could feel my frustration rising. Especially with couples in this much trouble, a strong alliance is critical. I took a breath, looking for a way to open my heart to Ben and Sarah. Seeing the anguish in both of them gave me a way in: "You both were so wishing to give all of you a good new start." They nodded. "This is so not what you had hoped for!" We lingered there with their grief and disappointment. As they each voiced their pain, I began helping them reach out to each other: "Okay to share that with Ben [Sarah]?"

Finally, I said, "I think I can help. But it might not be what you thought!" They looked wary but interested. I reassured them that although what I had to say might be hard to hear, understanding more about Bobby's experience would help them to right their ship. Tenderly and slowly, reminding myself to stay "soft and simple" (Johnson, 2012), I began walking with them through the year's events from Bobby's point of view. I layered each new piece of information about Bobby with my full understanding of Ben and Sarah's excitement about having found each other and their heartfelt wish to do the best for all the kids. Despite my care in delivering this news, Sarah collapsed into a sinkhole of guilt, sobbing, "What have I done to my boy?" Ben looked grim. But he offered, "This is so much harder than we thought it would be." I said softly, "I know. You have been trying to manage all this without a map. You're both feeling so alone!"

I took another step: "There is a way through, and there really are things that work! I'm not going to say it will be easy, and it might not be what you expected. But we can do this together." Again, good psychoeducation and a few basic interpersonal skills are sufficient to turn some stepcouples around within a few sessions. Ben and Sarah were not that couple. Our work extended over several years, moving among all three levels.

We began by putting some emergency measures in place: We built in more one-to-one time throughout the family, with special attention to increasing reliable alone time for Sarah and her son and making some intimate alone time for Ben and Sarah. Early sessions focused on psychoeducation and interpersonal connection, beginning with helping Ben and Sarah take in Bobby's experience of loss.

Early on, we turned to moving Ben out of his disciplinary role. I pulled out the Parenting Styles chart. We talked about "authoritative" parenting, identifying Ben's authoritarian and Sarah's permissive parenting styles. Like many stepfamilies in which a parent has died, this couple needed help grasping that Ben could not replace Bobby's father. In fact, Bobby needed the adults to focus on helping him grieve his father. He also needed both his stepfather and his mother to help keep his father in the family—talking about him, remembering special moments, noticing his absence at birthdays and holidays, perhaps finding a special place for a photo.

On the second, interpersonal level, as we saw earlier in this chapter, Ben and Sarah were using name-calling, dismissiveness, and defensiveness to engage over highly sensitive issues. I began helping them tap into their mutual vulnerability and their need for each other. We began deescalating their polarization polka by tracking their intensifying cycles. I often used "joining" to help them slow them down and establish some safety: "Sarah [Ben], can you take a breath? Can you find the place in your heart where you do understand what Ben [Sarah] is saying?"

It was often tough going. A few very productive satisfying sessions would be followed by difficult slogging. Meeting their stepfamily challenges required both Ben and Sarah to do some substantial pieces of individual intrapsychic work—at first alone with me, and, as they built more trust, in each other's presence. Although Ben initially looked like the villain in the piece, it became increasingly clear that Sarah's reactivity and passivity left both her son and her husband feeling overwhelmed and alone. We traced Sarah's own history of abandonment and began healing some of the wounded places that contributed to her reactivity. Slowly, she became more present with both her son and her husband, and more able to stand up to each of them with both confidence and heart. We did a number of mother–son sessions, helping Bobby voice his grief and devastation to his mom, and using "joining" to deepen Sarah's ability to express her compassion for Bobby's grief and his anger at having to share his mom with Ben and his younger stepsiblings.

Underneath Ben's harshness we found a little boy who had learned to tuck his own softness away from an annihilating father. Ben returned many times to that boy, at many different ages. At first, holding his tongue with Bobby required great effort. Over time, as Ben healed his own bruised young self, it became easier to take a breath and open his heart.

As in many healthy stepfamilies, several years down the road, insider–outsider challenges and parenting differences remained, but in much softer form. Sarah retained the disciplinary role with Bobby. As is common in stepfamilies, Bobby remained closer to his mother than to Ben. However, over time, focusing on "connection not correction" began to pay off for Ben. He and Bobby became rather good buddies.

CONCLUDING COMMENTS

Becoming a stepfamily confronts couples with a set of challenges that differs fundamentally from first-time families. Effective clinical work with stepcouples requires a solid understanding of these challenges, combined with knowledge of evidence-based "best practices" for meeting them. Given that 42% of Americans have a close steprelationship, this information needs to be a basic part of all clinicians' training.

SUGGESTIONS FOR FURTHER STUDY

Papernow, P. L. (2013). *Surviving and thriving in stepfamily relationships: What works and what doesn't*. New York: Routledge.

Smart Steps and *Together We Can*. Detailed training materials available from www.stepfamilies.info/smart-steps.php.

Videos and radio interviews. www.stepfamilyrelationships.com.

REFERENCES

Adler-Baeder, F., Russell, C., Kerpelman, J., Ketring, S., Pittman, J., Smith, T., . . . Stringer, K. (2010). Thriving in stepfamilies: Exploring competence and well-being among African American youth. *Journal of Adolescent Health, 46,* 396–398.

Adler-Baeder, F., & Schramm, D. (2006, November). *Examining and building the empirical knowledge on African American and Hispanic/Latino stepfamilies*. Paper presented at the annual conference of the National Council on Family Relations, Minneapolis, MN.

Ahrons, C. R. (2007). Family ties after divorce: Long-term implications for children. *Family Process, 46,* 53–65.

Amato, P. R., & Afifi, T. D. (2006). Feeling caught between parents: Adult children's relations with parents and subjective well-being. *Journal of Marriage and Family, 68,* 222–235.

Bonnell, K., & Papernow, P. L. (2019). *The stepfamily handbook: From dating to getting serious to forming a "blended family."* Kirkland, WA: CMC Press.

Braithwaite, D. O., Toller, P. W., Daas, K. L., Durham, W. T., & Jones, A. C. (2008). Centered but not caught in the middle: Stepchildren's perceptions of dialectical contradictions in the communication of co-parents. *Journal of Applied Communication Research. 32,* 33–55.

Brown, S. L., & Lin, I. (2012). The gray divorce revolution: Rising divorce among middle-aged and older adults, 1990–2010. *Journals of Gerontology B: Psychological Sciences and Social Sciences, 67,* 731–741.

Browning, S. C., & Artfelt, E. (2012). *Stepfamily therapy: A 10-step clinical approach*. Washington, DC: American Psychological Association.

Cartwright, C. (2008). Resident parent–child relationships in stepfamilies. In J. Pryor (Ed.), *The international handbook of stepfamilies: Policy and practice in legal, research, and clinical environments* (pp. 208–230). Hoboken, NJ: Wiley.

Crosbie-Burnett, M., & Helmbrecht, L. (1993). A descriptive empirical study of gay male stepfamilies. *Family Relations, 42,* 256–262.

Darling, N. (2013). *Parenting style and its correlates* (Report No. EDO-PS-99–3). ERIC Clearinghouse on Elementary and Early Childhood Education. http://athealth.com/topics/parenting-style-and-its-correlates-2.

de Jong Gierveld, J. (2004). Remarriage, unmarried cohabitation, living apart together: Partner relationships following bereavement or divorce. *Journal of Marriage and Family, 66,* 236–243.

Donahue, E., Garfinkel, I., Haskins, R., McLanahan, S., & Mincy, R. B. (2010). *Strengthening fragile families* (Brookings Series: Social Genome Project Research, 11 of 49). www.brookings.edu/research/reports/2010/10/27-fragile-families.

Dunn, J. (2002). The adjustment of children in stepfamilies: Lessons from community studies. *Child and Adolescent Mental Health, 7*(4), 154–161.

Eddy, W., Burns, A.T., & Chafin, K. (2014). *BIFF for coparent communication: Your guide to difficult coparent texts, emails, and social media posts*. Scottsdale, AZ: Unhooked Books.

El-Sheikh, M., Buckhalt, J., Cummings, E. M., & Keller, P. (2007). Sleep disruptions and emotional insecurity are pathways of risk for children. *Journal of Child Psychology and Psychiatry, 48,* 88–96.

Falicov, C. J. (2013). *Latino families in therapy* (2nd ed.). New York: Guilford Press.

Family Equality Council. (2019). *LGBTQ family building survey*. www.familyequality.org/fbs.

Ganong, L., & Coleman, M. (2017). *Stepfamily relationships: Development, dynamics, and interventions* (2nd ed.). New York: Springer.

Golish, T. D. (2003). Stepfamily communications strengths: Understanding the ties that bind. *Human Communication Research, 29,* 41–80.

Hetherington, E. M. (1993). An overview of the Virginia Longitudinal Study of Divorce and Remarriage with a focus on early adolescence. *Journal of Family Psychology, 7,* 39–56.

Jensen, T., & Howard, M. O. (2015). Perceived stepparent–stepchild relationship quality: A systematic review of stepchildren's perspectives. *Marriage and Family Review, 51*(2), 99–153.

Jeynes, W. H. (2007). The impact of parental remarriage on children: A meta-analysis. *Marriage and Family Review, 40,* 75–98.

Johnson, S. (2012, May–June). The great motivator: The power of emotion in therapy. *Psychotherapy Networker*, pp. 27–33, 56–57.

Kim, S. A., & Stein, E. (2018). Gender in the context of same-sex divorce and relationship dissolution. *Family Court Review, 56,* 384–398.

King, V. (2009). Stepfamily formation: Implications for adolescent ties to mothers, nonresident fathers, and stepfathers. *Journal of Marriage and Family, 71,* 954–968.

Kosciw, J. G., & Diaz, E. M. (2008). *Involved, invisible, ignored: The experience of lesbian, gay, bisexual, and transgender parents and their children in our nation's K–12 schools*. Gay, Lesbian and Straight Education Network. https://eric.ed.gov/?id=ed500474.

McHale, J., Waller, M. R., & Pearson, J. (2012). Coparenting interventions for fragile families: What do we know and where do we need to go next? *Family Process, 51,* 284–306.

Papernow, P. L. (2013). *Surviving and thriving in stepfamily relationships: What works and what doesn't.* New York: Routledge.

Papernow, P. L. (2018). Recoupling in mid-life and beyond: From love at last to not so fast. *Family Process, 57,* 52–69.

Papernow, P. L. (2021). Helping LGBTQ stepcouples meet their challenges. In M. Murphy & R. Harvey (Eds.), *Handbook of LGBTQ-affirmative couple and family therapy* (2nd ed., pp. 277–296). New York: Taylor & Francis.

Parker, K. (2011). *A portrait of stepfamilies.* Pew Research Center. www.pewsocialtrends.org/2011/01/13/a-portrait-of-stepfamilies.

Pasley, K., Rhoden, L., Visher, E. B., & Visher, J. S. (1996). Successful stepfamily therapy: Clients' perspectives. *Journal of Marital and Family Therapy, 22,* 343–357.

Payne, K. K. (2011). *On the road to young adulthood: Leaving the parental home* (Report No. FO-11–02). National Center for Family and Marriage Research. www.bgsu.edu/content/dam/BGSU/college-of-arts-and-sciences/NCFMR/documents/FP/FP-11–02.pdf.

Pruett, M. K., Ebling, R., & Insabella, G. (2004). Critical aspects of parenting plans for young children: Injecting data into the debate about overnights. *Family Courts Review, 42,* 35–59.

Reynolds, J., Houlston, C., Coleman, L., & Harold, G. (2014). *Parental conflict: Outcomes and interventions for children and families.* Bristol, UK: Policy Press.

Sassler, S., & Lichter, D. T. (2020). Cohabitation and marriage: Complexity and diversity in union-formation patterns. *Journal of Marriage and Family, 82,* 35–61.

Schwartz, R. C., & Sweezy, M. (2019). *Internal family systems therapy* (2nd ed.). New York: Guilford Press

Siegel, D. J. (2012). *The developing mind* (2nd ed.). New York: Guilford Press.

Stewart, S. D. (2007). *Brave new stepfamilies.* Thousand Oaks, CA: SAGE.

Stykes, B., & Guzzo, K. B. (2015). *Remarriage and stepfamilies* (FP-15–10). National Center for Family & Marriage Research. www.bgsu.edu/ncfmr/resources/data/family-profiles/stykes-guzzo-remarriage-stepfamilies-fp-15–10.html.

Stykes, J. (2012). *Nonresident father visitation* (Report No. FP-12–02). National Center for Family and Marriage Research. www.bgsu.edu/content/dam/bgsu/college-of-arts-and-sciences/ncfmr/documents/fp/fp-12–02.pdf.

Titlestad, A., & Pooley, J. A. (2014). Resilience in same-sex parented families: The lived experience of adults with gay, lesbian, or bisexual parents. *Journal of GLBT Family Studies, 10*(4), 329–353.

U.S. Census Bureau. (2014). *U.S. population projections: 2014–2060.* www.census.gov/population/projections/national/2014.html.

van Eeden-Moorefield, B. (2013). *The experiences of stepfamilies headed by gays and lesbians* (Online Training Institute Level 1, Module 6). National Stepfamily Resource Center. www.stepfamilies.info/training/view.php?mod=6.

van Eeden-Moorefield, B., & Pasley, B. K. (2013). Remarriage and stepfamily life. In G. W. Peterson & K. R. Bush (Eds.), *Handbook of marriage and the family* (3rd ed., pp. 517–546). New York: Springer.

van Gelderen, L., Gartrell, N., Bos, H., van Rooij, F. B., & Hermanns, J. M. A. (2012). Stigmatization associated with growing up in a lesbian-parented family: What do adolescents experience and how do they deal with it? *Children and Youth Services Review, 34,* 999–1006.

White, L., & Gilbreth, J. G. (2001). When children have two fathers: Effects of relationships with stepfathers and noncustodial fathers on adolescent outcomes. *Journal of Marriage and Family, 63,* 155–167.

Wittman, J. P. (2001). *Custody chaos, personal peace: Sharing custody with an ex who is driving you crazy.* New York: Penguin.

Zietlow, A., & Cahn, N. (2017). *Homeward bound: Modern families, elder care, and loss.* New York: Oxford University Press.

CHAPTER 23

Therapy with Queer Couples

Deb Coolhart

BACKGROUND

Queer couples often come to therapy seeking help with problems similar to those of cisgender/heterosexual couples. For example, queer couples seek help with communication, finances, sex, parenting, and division of labor (Green & Mitchell, 2015). And while it is important to acknowledge the similarities between queer couples and cisgender/heterosexual couples, it is also important to be aware of the ways in which queer couples may be different. Because queer couples are often embedded in contexts that do not validate, normalize, and affirm their identities and experiences, it is vital to understand how minority stress can create both challenges and resiliencies (Meyer, 1995) for couples. Queer people are largely excluded from mainstream social messages and expectations about identity and relationships that are centered around cisgender/heterosexual experiences. While it can be stressful for queer people to not be offered role models or road maps, it can also lead to deeper self-discovery and a quest for congruence. Queer people get to explore, navigate, and narrate their own journeys through identity and relationships in unique ways that are not as confined by heterosexism and cisgenderism.

This chapter begins with a description of the choices I have made about language, a foundation for how minority stress can cause strain for queer individuals and couples, and a relational intersectional framework for working with queer couples. I then discuss core understandings of queer couples, identifying some of the unique relational dynamics many queer couples construct, alternatively to being confined by cisnormative/heteronormative relationship expectations. The discussion interweaves specific suggestions for clinical practice throughout, but then offers more general implications for therapy with queer couples. The chapter concludes with several case illustrations.

Striving for Inclusive Language and Facing the Challenges of Binaries

When discussing couples who are not cisgender/heterosexual, the terms “lesbian couples” and “gay male couples” are often used. This language can be limiting, as it assumes the sexual orientation of partners to be lesbian or gay and erases the identities of bisexual and sometimes trans folks who may be part of these couples. For example, a “lesbian couple” may not include a lesbian-identified person at all; a couple could comprise two bisexual women. In order to promote inclusivity and curiosity around the diversity of these couples, I use the term “queer couples” to describe relationships that include at least one person who does not identify as cisgender/heterosexual. It’s important here to note that the term “queer” has been used historically as a derogatory word and so is not universally used and embraced in lesbian, gay, bisexual, and trans communities.

Therefore, it is important to explore language with clients and adopt terms that are self-narrated. Many lesbian, gay, bisexual, and trans people do embrace the term. In addition to being inclusive of diverse genders and sexual orientations, the word "queer" has a way of uniting all of the communities it encompasses, rather than dividing queer people into categories. The term "queer" has also been passionately reclaimed by activists, academics, and advocates, and is now often referred to as a resistance term, reclaimed through political work by the community it used to subjugate.

Another challenge with language arises when discussing the differences between queer couples comprised of two females and couples comprising two males. Identifying the gender (female/male) is more inclusive than labeling with identity (lesbian/gay male) because it makes space for diverse sexual orientations (i.e., bisexual, pansexual); binary trans folks (transwomen and transmen) are also included within this language structure, as they identify as female or male. However, the terms "female" and "male" are binary terms, thus excluding those who identify as nonbinary.

Nonbinary people are self-identifying in growing numbers and describing an experience of feeling neither female nor male, both female and male, and/or some fluid/fluctuating experience of being female and male. While nonbinary individuals have begun to be included in research on queer couples, very little research has focused on the unique experiences of nonbinary people in relationships. So, although I conceptualize nonbinary people under the umbrella of queer, it is important to acknowledge how much is still to be learned about nonbinary experiences and whether they may identify with more generalized experiences of queer female and/or queer male couples. While I use the terms "queer female couples" and "queer male couples" to be inclusive of bisexual and binary trans folks, I also acknowledge that this language is problematic. At the time of this writing, I am not aware of language that adequately addresses this challenge. My hope is that as time goes on and we listen more to the experiences of nonbinary people, our language and conceptualizations can evolve to be less binary, more creative, and more inclusive.

Minority Stress

Meyer's (1995) minority stress model describes both external and internal sources of stress queer people experience as a result of being a gender or sexual minority. External or environmental sources of stress include experiences of discrimination, microaggressions, assaults, and other general threats to safety or security. Internal sources of stress include anticipation of mistreatment, internalized homo-/bi-/transphobia, and concealment of sexual and gender identity. Researchers have found associations between minority stress and variables such as relationship quality, domestic violence, health, and substance abuse in queer women (Balsam & Szymanski, 2005; Lehavot & Simoni, 2011) and health risk behaviors, substance use, depressive symptoms, and body image concerns in queer men (Hamilton & Mahalik, 2009; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Kimmel & Mahalik, 2005). One facet of minority stress, internalized homophobia, can lead to lowered self-esteem and increased loneliness (Szymanski & Chung, 2001), as well as increased depression (Szymanski, Chung, & Balsam, 2001). In queer couples, greater levels of internalized homophobia can be predictive of greater daily stress, more severe conflict, and poorer relationship quality (Totenhagen, Randall, & Lloyd, 2018). As clinicians, we need to stay curious about minority stress, including internalized homo-/bi-/transphobia, that couples are dealing with, as it may bring additional strain to the relationship.

Researchers have also explored how multiple minority stressors impact queer people of color. Black lesbians have reported racism as a common and significant stressor, also reporting that they contextualized their experiences of sexism and heterosexism through the prism of racism (Bowleg, Huang, Brooks, Black, & Burkholder, 2003). Queer people of color have also reported racism in queer communities, heterosexism in racial/ethnic minority communities, and racism in dating and close relationships (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Because queer couples often are often partnered cross-culturally (Gates, 2012), attending to racism that may be occurring within couple relationships may be particularly important. Queer couples are experiencing the identities of race, gender, and sexual orientation simultaneously (along with other dimensions of identity), making a relational intersectional framework necessary to understand and support queer couples.

The Relational Intersectional Framework

Much of the existing literature about queer couples has been centered around the experiences of dominant groups. For example, research in couple and family therapy journals has predominantly focused on the experiences of men and White people (Hartwell, Serovich, Reed, Boisvert, & Falbo, 2017). Thus, when experiences of marginalization due to sexual orientation have been explored, other systems of oppression that may also impact queer people, such as White supremacy, have been underexplored (McEachern, Coolhart, & Watson, 2022). So when digesting this literature, it is important to acknowledge that we don't know how much can be generalized to queer people occupying multiple marginalized identities (McEachern et al., 2022). In other words, if the literature is based on the experiences of gay men and White people (and probably cisgender people), how many of these experiences translate to the experiences of queer people of color, queer women, and trans people? And what more do we need to learn to understand how facets of identity, such as race/ethnicity, socioeconomic status (SES), and physical/cognitive ability impact and inform the experiences of queer people?

To address these questions, an intersectional approach is needed to consider how queer couples' experiences are informed by other parts of their identities. The concept of intersectionality can be traced to early writings by Black feminists, who described "simultaneity," asserting that women's lives are shaped by the simultaneous experiences of sexual identity, race, class, and physical/cognitive ability (Combahee River Collective, 1977). Later, Crenshaw (1991) introduced "intersectionality" to feminist theory, describing it as the ways in which oppressive institutions such as racism and classism are interconnected and cannot be examined separately from one another. Considering intersectionality while working with queer couples means to understand not only how their experiences have been shaped by sexual orientation and gender identity, but also how race, SES, religious background, age, educational attainment, immigration status, ability, and so on, also impact people's experiences (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim).

Much of the early literature discussing the impact of various other identities on queer people followed a kind of additive model, in which the more marginalized identities they have, the more burden they experience. Addison and Coolhart (2015) proposed the use of a relational intersectional framework for therapists working with queer couples, challenging the additive approach, which assumes more marginalized identities necessarily equals more burden. Through this lens, we may sometimes find that identities we think of as privileged can actually intersect in ways that create more stress. As noted by Addison and Coolhart, Christianity is an identity with tremendous privilege and power in North America, though balancing both a queer and Christian identity can lead to challenges and conflicts, such as struggling to develop a queer-positive view of self. Queer Christians may also struggle within queer communities, which sometimes have a negative view of Christianity due to religiously based experiences of oppression and pain (Addison & Coolhart, 2015).

The relational intersectional framework (Addison & Coolhart, 2015) also implies that the complex identities of each individual will further intersect in couple relationships. Essentially, this means that intersectionality becomes even more complex when we think about people in relationship with each other. In couple relationships, each partner brings their own unique intersectional identities that then overlap with the other partner's intersectional identities. It may be helpful to think about a person's multifaceted identities as a set of circles that intersect with each other. Each circle represents an aspect of identity such as, race, gender, sexual orientation, ability status, religion, SES, or any other number of parts that make up a person's identity. These intersecting circles are already complex when we think about one person's intersections. Then, when we are working with a couple, there is not only the identity intersections of an individual we have to keep in mind but we now also have to consider the cultural intersections of each person in the system and how those intersections interact with each other (picturing two sets of intersecting circles now intersecting with each other).

While relational intersectionality is a helpful framework for working with all couples, it is especially important with queer couples. Queer couples are often in cross-cultural relationships in which partners differ in their race, ethnicity, religious background, age group/generation, educational attainment, and/or SES (Gates, 2012). This means that they are more likely to have identities that intersect with each other in complex ways. Additionally, when thinking about intersectionality with queer couples, there are multiple ways that queer identities intersect with each other. For example, a pansexual trans woman partnered with a cisgender heterosexual man would experience a very different relational intersection if she were partnered with a cisgender lesbian.

Even gender expression or gender socialization may come into play as complex intersections in queer couples. For example, let's consider David and Luis. David is a White cisgender gay man raised in a rural White conservative context who, since childhood, demonstrated many expressions typically deemed feminine. As a result, he experienced regular devaluing in his family context and bullying and assault in larger contexts. He doesn't feel his partner Luis can understand his experiences of marginalization and how David has been informed by them. Luis is a Black gay cisgender man who expresses his gender in a way that is largely seen as masculine. Thus, most of his experiences of marginalization and mistreatment have been centered around racism rather than misogyny. He does not discuss race and racism with David, assuming he would not understand. While the sources of marginalization for David and Luis are different, a therapist may be able to help David and Luis connect to each other's experiences by recognizing that while they are different, both David and Luis have experienced feelings of invalidation, fear, helplessness, anger, and resilience because of their marginalization.

Now let's think back to the intersecting circles. In therapy with queer couples, a third set of intersecting circles enters the relationship, the intersecting identities of the therapist. Relational intersectionality further expands to include the therapist's multiple identities, and their overlap with each partner's identities (Addison & Coolhart, 2015). As therapists, we cannot fully separate self from our work; therefore, we must engage in self-of-the-therapist work to reflect on how our multiple social locations impact who we are as therapists and how these social locations show up in our work with queer couples.

Any therapist working from any theoretical perspective can utilize relational intersectionality. It is not a therapy theory with its own specific interventions; rather, it is a lens through which we can approach our work with queer couples. Consider thinking about this relational intersectionality when working with a couple, Rachel and Trevor. Rachel identifies as a heterosexual cisgender woman who comes from an upper-middle-class background. Trevor identifies as a heterosexual trans man from a working-class background. When these two people with different identities are in a relationship, their identities intersect with each other. This is relational intersectionality.

Thinking about how the multifaceted identities of these two partners intersect with each other provides clues about how we might conceptualize their relationship and what might be important to explore with them clinically. In this couple, it happens that one of Rachel and Trevor's biggest points of conflict is finances. If we consider the differences in Rachel and Trevor's socioeconomic backgrounds, it provides a lens through which we can understand their struggles. Rachel gets frustrated with Trevor for being too controlling and too stressed out about money. This may be connected to Trevor's background, when worrying about having enough money was a central part of his experience growing up. On the other hand, Trevor gets frustrated with Rachel's refusal to make plans for finances. Rather than staying committed to a financial plan, Rachel often splurges financially and makes unplanned purchases. This may be connected to Rachel's upbringing, in which money was not a huge source of stress, she was able to have pretty much whatever she wanted, and finances always worked themselves out. Helping Rachel and Trevor to understand how their differences are connected to their families of origin and social class backgrounds could help them to have compassion for the other person's perspective.

Looking at other aspects of relational intersectionality with Rachel and Trevor, their experiences with sexuality and gender are also important. Rachel often finds herself trying to take care of Trevor, assuring him that he is a wonderful partner; at the same time, Rachel struggles to speak up for her own needs in the relationship. This may be connected to Rachel's gender and sexuality socialization, in which she learned that women take care of others' needs over their own, especially in a relationship with a man. On the other hand, as Trevor makes demands in the relationship that he expects Rachel to meet, he also struggles to feel secure in the relationship. This could be connected to Trevor's gender socialization as a man, in which he learned that it is okay for a man to ask for what he needs and to expect that his needs will be heard. There could also be added complexity around Trevor's experience as a transgender man and worries that his heterosexual partner may leave him for a cisgender man; therefore, he needs additional reassurance.

Now let's think about how a therapist's identities might intersect with this couple's identities. I identify as a bi/pansexual cisgender woman who comes from a middle-class background. If I am the therapist for this couple, my identities then also intersect with the clients' identities. I happen to share some aspects of identity with Rachel in that I was socialized as a cisgender female and come from a middle-class background. This might mean that I have an easier time understanding her views around these dynamics and that I will need to be careful not to side with her, for example, agreeing that Trevor is too stressed about money. My pansexual identity may also have an impact on my work with this couple, in which I could have more compassion for Trevor's struggle around having a marginalized queer identity and the resulting insecurity he experiences in the relationship. In this case, I may be able to use my shared identities with Rachel to join with her and also my differing experience with sexuality to help her understand the impacts of Trevor having a marginalized experience, where his insecurity actually makes a lot of sense.

At times, these intersectional experiences of shared or differing identities may be disclosed directly with clients. For example, with Trevor and Rachel, I may share overtly my pansexual identity or my years of experience working with the trans community. This sharing may be important because I am a cisgender straight-passing woman; therefore, this couple might assume that I would naturally "side" with Rachel. I relate to Rachel as a cisgender woman and the frustration of learning to put others' needs above my own; I may also stretch Rachel's perspective by talking about the additional stress and burden queer people experience, pointing out that the invalidation Trevor has received about his identity could naturally lead to insecurities that aren't his fault. On the other hand, it may sometimes be best not to share how my identities intersect if this places me on the side of one partner. For example, with Rachel and Trevor, I may privately acknowledge how my class background impacts my attitude toward money and use this sensitivity to facilitate empathic joining on a more covert level. Regardless of whether I share my intersectional experiences directly with clients, it is vital to keep in mind how they are impacting my therapeutic work with couples.

CORE UNDERSTANDINGS ABOUT QUEER COUPLES

The experiences of queer couples are vastly diverse and shaped by not only sexual and gender identities but also other social locations, making it impossible to cover all of these experiences in one chapter. The goal here is to review some of the unique relational dynamics in the early literature on queer couples, and to expand these early learnings based on more contemporary understandings and intersectional considerations. First, I discuss some of the more commonly addressed themes for queer couples, including gender role socialization, scripts, and couple dynamics; diversity in family structure; and being "out" and identity management. Following this I consider less commonly discussed topics, including consensual nonmonogamy and polyamory (Henrich & Trawinski, 2016) and how these relationships are constructed in some queer couple relationships, as well as some of the unique dynamics often present in couples including bisexual and trans people.

Gender Role Socialization, Scripts, and Couple Dynamics

After mental health fields began to depathologize homosexuality in the 1970s, couple and family therapy literature shifted away from discussing how to treat homosexuality. Yet early writings on queer couples (1980s) often explored how queer couples differed from cisgender heterosexual couples in how they regulated closeness and distance. Queer female couples were often pathologized for being enmeshed, and queer male couples were often pathologized for being disengaged. The closeness in queer female relationships was attributed to both partners having a feminine gender socialization, which teaches emotional connectedness and interdependence. The independence in queer male relationships was attributed to both partners having a masculine gender socialization, which teaches emotional distance and individualism.

While this foundational observation of queer couples is helpful in some ways (discussed below), it is also problematic. First, closeness and independence in queer couples are not necessarily signs of pathology, enmeshment, or disengagement. In fact, queer couples demonstrate many strengths that suggest otherwise. Second, queer couples may not share similar experiences of gender socialization depending on other aspects of their identities and gender expressions (McEachern et al., 2022). For example, trans people often have gender socializations that are not congruent with their gender identity, so while they may be part of a female couple, they may be bringing with them a foundation of masculine gender socialization. Furthermore, two men in a cross-cultural relationship may be bringing with them very different gender socializations from their respective cultures.

Further research has shown that queer couples demonstrate strengths in how they relate to each other. Gottman and colleagues (2003) found that queer couples were less belligerent and domineering, used more humor, and demonstrated more positive affect overall than did cisgender heterosexual couples when initiating and discussing a topic of conflict. In a review of research on queer couples, Rostosky and Riggle (2017) noted several key strengths, including high levels of intimacy, commitment, egalitarian practices, and respect for individual practices. These findings do not support the idea that queer couples manifest a deficit in how they regulate closeness and distance. Some authors have used strengths-based interpretations, for example, by explaining the closeness in queer female couples as an adaptive response to adverse conditions (Biaggio, Coan, & Adams, 2002).

Additionally, the gender role socialization in a queer female couple may lead to strengths in dealing with stress and engaging in conflict. According to Taylor and colleagues (2000), in times of stress, women may be more likely to respond in a "tend and befriend" rather than a fight-or-flight response. This response can lead to increased safety, reduced distress, and sharing of resources and responsibilities, thus reducing feelings of vulnerability (Taylor et al., 2000). Similarly, Connolly and Sicola (2005) found that queer female couples are effective at conflict resolution and empathic attunement to one another, and report increased satisfaction in their relationship as a result. Queer female couples also show strengths related to forming initial emotional connections and foundations for romantic love, and they are more likely to ritualize the love in their relationships than other relationship configurations, celebrating special occasions and creating couple rituals (Connolly, 2012). These various strengths in queer female couples may contribute to their higher reported relationship quality (Kurdek, 2008).

Because of these various strengths in queer female couples, therapists may expect these couples to have a natural ability to process emotions deeply with each other. Queer female couples often are not passive with their communication and instead engage in intentional communication in order to maintain their relationships (McEachern et al., 2022). Many are comfortable expressing and listening to vulnerable emotions, making queer female couples ready to do the "work" of therapy. They often continue this work at home and deepen conversations between sessions. Therefore, using an emotion-focused approach may be particularly useful with queer female couples, exploring the roots of pain and healing attachments within the couple relationship (also see Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan).

While pathological enmeshment/fusion should not be assumed in queer female couples, certainly some couples experience an abundance of closeness at the expense of individuality. There is a popular joke in the queer community that identifies a common coupling pattern for queer female couples: "What does a lesbian bring on her second date? A U-Haul!" When queer women start relationships, they often experience a rapid sense of intimacy, closeness, and commitment. Again, this can be a strength, though in the rush of building a couple identity, sometimes aspects of self can get lost. Thus, some queer female couples may present in therapy feeling suffocated in their relationship or feeling like they no longer have space to be an individual. With these couples, therapists should both point out the strength in the couple's closeness and facilitate a focus on how the two individuals might grow.

The independence in many queer male couples may also lead to some strengths or benefits, as well as some challenges. For example, queer male couples often successfully negotiate consensual nonmonogamous relationships that lead to feeling both closeness between partners and personal freedom (to be discussed in more detail later). Tunnell (2012) talked about some unique challenges queer male couples may experience related to gender socialization. For example, a man in conflict with another man may be more likely to escalate conflict, not backing down rather than shutting down, as is common for men in heterosexual relationships. Furthermore, male socialization can create challenges in the regulation of emotional closeness, in which males are shamed by other males for expressing emotion and therefore learn to protect themselves by keeping their emotional lives private from other males. Tunnell suggests the therapeutic task is to help queer male couples regulate closeness and distance, balancing autonomy and connection.

Another way in which queer couples differ from cisgender heterosexual couples is in the lack of prescribed gender roles in a couple relationship. In queer couples, there is a need to negotiate roles and activities because there is no gender role "script" for queer partners (Green & Mitchell, 2015). This can free couples to negotiate roles. Some research shows that queer couples, and particularly queer female couples, engage in a more egalitarian division of domestic labor than do cisgender heterosexual couples (e.g., Perlesz et al., 2010). When queer couples do not share household labor equally, they may have a "specialized" division of labor in which the emphasis is on fairness rather than equality (Esmail, 2010). These divisions of labor may be shaped by time availability and personal preferences, as well as broader social context, such as labor force participation and citizenship (Kelly & Hauck, 2015). While some of these negotiations can be seen as strengths (a focus on fairness, consideration of personal preferences), dynamics of power also may also come into play, making a relational intersectional lens particularly important.

Clinicians should stay curious about how gender socialization and scripts shape each unique queer couple, particularly in trans-including couples. A trans partner may be impacted by both their gender identity and their gender socialization, which was likely not aligned with their gender identity. For example, trans men who were raised with feminine gender socialization (prior to coming out or transition) may have different experiences from cisgender men and may have been taught to value communication and emotions. Thus, couples that comprise trans men with queer females might experience some of the previously discussed strengths or challenges associated with queer female couples. On the other hand, it is also possible that gender normative roles emerge as more important in these relationships, in which occupying a more masculine place in the relationship is important in order to affirm the trans man's gender identity. More research is needed to understand how both binary and nonbinary trans experiences uniquely shape couple dynamics.

Diversity in Family Structure

Queer families, by definition, are diversely created and structured, and usually have family systems with one or more nonbiological parents (although in some trans-including couples it is possible for both partners to be biological parents). Queer families often include children from prior heterosexual relationships and/or create children through donor procedures or adopting children within the queer partnership. When queer couples become parents, they may experience additional minority stress, impacted by heterosexism and "cissexism" (the belief that cisgender people's gender expressions and embodiments are more natural and legitimate than those of trans people). These stressors come from society, extended family, other biological parents, and even the children themselves, depending on their ages (Addison & Coolhart, 2015). For example, a queer parent who left a heterosexual relationship with their child's other parent may be dealing with hostility related to homophobia and the dissolution of the previous relationship. Queer couples in the process of adoption may be dealing with homo-/bi-/transphobia within adoption systems and/or from birth parents. And kids being raised in queer families are inundated with messages that position their families as different, invalid, or pathological. Thus, therapists should be curious about the multiple angles from which queer families may be experiencing minority stress, creating space to validate and support these dynamics.

While having diverse family structures and multiple parents have often been discussed as challenges, for many families, these various family dynamics can also be strengths. While queer couples may face stress or frustration about not being able to become parents as easily as most cisgender heterosexual couples, a potential advantage is that queer couples can think creatively about building a family, choosing a path to parenthood that is well thought out and most congruent for the couple. Queer couples rarely get pregnant accidently, making their children very planned for and desired. In some queer families, biological parents outside of the couple may be involved in children's lives and to differing degrees. For example, in my family, I gave birth to my son while in a queer relationship, using a close friend as a sperm donor. He has played a peripheral role in my son's life, while my son has been primarily parented by myself and his other mom. Thus, queer families sometimes have more than two parents or caregivers, which can provide additional emotional, practical, and/or financial resources and increased flexibility.

Because the children of queer parents are embedded in a larger culture that invalidates and devalues their family structures, queer parents must also be conscious of how to talk to their children about homo-/bi-/transphobia and hetero-/cissexism. They may need to make decisions, such as how to answer their children's questions and how to handle attacks on their parenting abilities or rights. Some families may also negotiate how to manage family information outside the home, such as keeping a parent's trans identity private. For some queer couples, such decisions could become sources of conflict or even splits in the couple system (Addison & Coolhart, 2015). For example, if one partner's family of origin is not supportive of the couple or their choice to become parents, the couple may be in conflict about the role of the extended family in the children's lives, struggling to balance the value of family connection with the desire to protect kids from harmful messages.

Being "Out" and Identity Management

One challenge for some queer couples arises when partners differ in their degree of "outness." Couples may experience tension around how long each partner has identified as queer and whether each has come out in various aspects of their personal lives such as work, family of origin, and community. For example, if one partner is not out to their family or their family is not supportive, they may not invite their partner to holiday and family functions. This could lead to the partner feeling like they are not prioritized and possibly feelings of pain, loneliness, insecurity, and resentment. In another couple, one partner may feel more comfortable being out in the larger community, expressing affection for their partner publicly. If the other partner is uncomfortable with being publicly identified as queer, the affectionate partner may feel hurt or rejected. Clinicians should talk with queer couples about these differences and explore how they are related to the larger systems of homo-/bi-/transphobia, internalized homo-/bi-/transphobia, and concerns about safety. Therapists may ask, "In what spaces are you 'out' as a couple? In what spaces are you not 'out' as a couple? Are there differences between the two of you in your comfort being 'out' or expressing affection in certain spaces? What happens when these differences arise? How do you understand why you differ from your partner in your comfort around being 'out'?"

The relational intersectional framework takes into consideration how decisions around outness may be balanced with other aspects of identity. For example, a person may need to maintain relationships with racial, ethnic, and/or religious communities in which the consequences of coming out would be detrimental. Connolly (2012) suggested thinking in terms of "identity management," rather than all or nothing thinking about being out or not. A person might manage their identity differently in different spaces and those choices might be what is most adaptive for the person. Thinking in terms of identity management deemphasizes outness as the best or most healthy choice.

Glass and Few-Demo (2013) found in their study of Black queer female couples that extended family members supported them individually in their roles, such as mothers and daughters, but not necessarily in their roles as partners and as a couple. Couples also reported that their partners were accepted as "helpful friends" instead of romantic partners. These couples may choose not to show affection toward each other in front of their extended family in order to maintain connection with their extended family. This deemphasizes outness as the healthiest choice and instead emphasizes family connection as the couple's healthiest choice. Glass and Few-Demo also found that couples reported deemphasizing their roles as partners within church communities and emphasizing their roles as mothers and sisters. They described making their relationships "invisible" for church, and attending church for themselves, not for the couple relationship, again deemphasizing the importance of outness in order to emphasize the partners' need for religious connection. This study is a good example of how challenging it can be to balance multiple aspects of identity, and the choices and compromises that sometimes need to be made in order to access support.

Consensual Nonmonogamy and Polyamory

"Consensual nonmonogamy" refers to any relationship in which all partners explicitly consent to multiple, concurrent sexual and/or loving relationships. It is an umbrella term that can take an infinite number of forms in different relationships, some of which I discuss here. Most therapists likely receive little to no training on working with consensually nonmonogamous relationships, as both the field of relational therapy and the culture at large are monocentric, where monogamy is centered as the one correct kind of partnership. Thus, it is not surprising that research suggests people generally carry a stigma surrounding consensual nonmonogamy, judging nonmonogamous arrangements negatively, and a halo effect surrounding monogamy, judging monogamous arrangements positively (Conley, Moors, Matsik, & Ziegler, 2012).

This monocentrism shaded much of the early literature about how consensual nonmonogamy was practiced in queer relationships. As it became evident that queer people, particularly queer male couples, seemed more often to choose or prefer nonmonogamous relationships, early writing focused on negative aspects of consensual nonmonogamy, such as concerns regarding HIV/AIDS, other sexually transmitted infections, and issues of boundaries and jealousy. The more recent literature discusses consensual nonmonogamy in a less pathological way, acknowledging not just the challenges of negotiating these relationships but also the strengths that consensually nonmonogamous couples sometimes experience as a result of these arrangements.

Consensual Nonmonogamy in Queer Male Couples

First, it is important to acknowledge that many queer male couples are monogamous, and some choose other forms of polyamory. The purpose here is to describe the form of consensually nonmonogamous arrangements that many queer male couples choose to construct. Typically, these arrangements privilege the couple relationship as the primary relationship, and other partners are considered secondary. Some couples may define their relationship as having "monogamy of the heart and not the genitals" (LaSala, 2005, p. 9) or emotional monogamy (Malone et al., 2018), separating the concepts of love and sex. In other words, queer male couples often have arrangements in which the couple is committed in their love for each other and at the same time, they may negotiate boundaries around having sex with other people. Under the umbrella term of "consensual nonmonogamy," this type of arrangement may be aligned with the term "open relationship," and may be practiced by not just queer male couples but also couples of any genders and sexualities.

The ways queer male couples negotiate the terms of these nonmonogamous relationships may vary widely. Some couples negotiate rules that limit the likelihood of loving feelings developing with sexual partners outside the primary relationship. For example, there may be limitations agreed upon, such as only having sex with an outside partner once, or only having outside sex while away on travel, and so forth. Other couples may choose to engage in outside sex only when they are together, involving a third person. Also, it is not uncommon for queer male couples to choose monogamy in the beginning of a relationship, then negotiate a nonmonogamous relationship later (Malone et al., 2018; Tunnell, 2012). Thus, couples discuss these arrangements openly (and if they don't, we can help in therapy!), and agree/consent together about what outside sex looks like in the context of their relationship. It is important to distinguish between the concepts of infidelity/cheating and consensual nonmonogamy. When couples consent to outside sex and agreed-upon boundaries, and these boundaries are respected, this sex is not cheating. However, it is possible for betrayal/cheating/infidelity to occur within a consensually nonmonogamous relationship if the agreed-upon boundaries are broken.

Queer male couples may face challenges in their consensually nonmonogamous relationships, such as breaches in their agreements, dealing with feelings of jealousy, or achieving clear communication in the negotiation of boundaries. However, they may also experience benefits of consensual nonmonogamy. Queer male couple relationships may be positively impacted by being able to negotiate together the boundaries that include outside sex, and experience affirmation of the couple's commitment and affirmed trust (LaSala, 2005). Other couples may experience improved communication and increased intimacy as a result of needing to talk through the nonmonogamous agreement clearly (Malone et al., 2018). Queer male couples may also experience feelings of personal and sexual freedom as a result of having a consensually nonmonogamous relationship (LaSala, 2005). Therefore, it is possible that couples experience both an elevated experience of intimacy within the relationship, while also gaining the benefit of increased freedom.

In discussing her conceptualization of what is needed to maintain both intimacy and passion in couple relationships, Perel (2006) described a paradox that needs to be balanced between commitment and freedom. While intimacy, security, familiarity, and commitment are necessary in couple relationships to create safety, too much of these qualities may create boredom, sapping passion and eroticism. Perel described this dynamic as "fire needing air," that in order to maintain the heat and the passion, one partner must be able to step back, experience self as separate, and see their partner with new eyes. So, if queer male couples report feelings of personal freedom as a result of consensual nonmonogamy (LaSala, 2005), according to Perel's theory, they may also experience increased desire within the primary couple relationship.

I would be remiss not to discuss sexual safety and how many queer male couples also negotiate these boundaries in consensually nonmonogamous relationships. Condomless sex between primary partners is more common than in casual partnerships and may signify intimacy, trust, and commitment (Malone et al., 2018). Many queer male couples with nonmonogamous agreements require that condoms always be used when having outside sex. However, we are now in the era of biomedical HIV prevention, in which we have access not only to condoms but also to preexposure prophylaxis (PrEP), which is a highly efficacious medication used to prevent HIV transmission and can be taken daily or on-demand by an HIV negative partner. The use of PrEP is common for queer male couples in nonmonogamous agreements[1] to keep members of the primary relationship safe and to continue to have safe condomless sex within the primary partnership (Malone et al., 2018).

Polyamory

Another way to conceptualize and practice consensual nonmonogamy, "polyamory" is an honest and transparent agreement among partners to love more than one person (Henrich & Trawinski, 2016). Different from the open relationship arrangements described earlier, which focus more on sex and often forbid love with outside partners, polyamory is based in a belief that it is possible and advantageous to love more than one person at a time. In monogamous relationships, this idea may feel very threatening, and a person may feel that if their partner loved someone else, there wouldn't be enough love/time/resources left for them. Polyamorists refer to this thinking as a starvation economy and instead adopt an abundance mentality, where love for one person doesn't mean there is any less love for another person (Fierman & Poulsen, 2011).

There is a tremendous amount of diversity in the way people construct polyamorous arrangements, so the goal here is not to cover all of them, but rather to provide a basic understanding of some of the ways poly relationships differ from monogamous relationships. While many poly people identify as queer, cisgender heterosexual people may also be polyamorous. Thus, polyamory can be seen as an identity rather than a sexual orientation (Henrich & Trawinski, 2016). In some polyamorous relationships, all partners identify as polyamorous, and in others, only some do so (Henrich & Trawinski, 2016).

Like the open relationship style described earlier, some poly relationships are based on one relationship as a primary relationship that gets prioritized over secondary partners. However, in some poly relationships, there is no hierarchy, and all relationships are treated as equally important. In some poly arrangements, multiple people are all involved together in one relationship, and in others, individual partners pursue their own private relationships with other partners. Because there are so many nuances to how poly relationships get constructed, poly people need to be willing to engage in a tremendous amount of communication, requiring deep self-knowledge, radical honesty, and congruency.

Understanding how jealousy functions in a polyamorous relationship is quite important because it tends to look really different than in monogamous relationships. In monogamous relationships, jealousy tends to be seen as a negative feeling, and the approach often taken is to remove the stimulus of the jealousy. For example, if one partner is jealous that the other partner is texting or talking to another person, then the expectation is often that they stop communicating with that third person. In polyamorous relationships, jealousy is seen as neither negative nor positive; rather, it is just an emotion that needs to be acknowledged and worked through in the relationship (Fierman & Poulsen, 2011). If a person's jealousy is due to a feeling of insecurity, for example, attending to the source of that insecurity would be a way to work through jealousy. There may be ways that both the person feeling insecure and the partner can care for the insecurity. Thus, jealousy in poly relationships is not a reason to end a relationship, and the behavior causing jealousy does not necessarily need to be stopped (Fierman & Poulsen, 2011).

Poly relationships often experience benefits from partners being involved with outside loves. There is an acknowledgment that starting a new relationship can be invigorating, and that the feeling of "new relationship energy" is a positive experience, involving feelings of excitement and infatuation. So, when one partner watches their partner fall in love with someone else, they are happy that their partner is experiencing such joy. They may feel "compersion," which means having positive feelings about a partner's other intimate relationships or finding joy by observing a partner's joy (Fierman & Poulsen, 2011). Poly relationships trust in the stability of their established relationships and also appreciate "old relationship energy," which involves feelings of comfort and security.

Poly relationships are faced with internalized and institutionalized marginalization and challenges around disclosure (Henrich & Trawinski, 2016), giving them some common ground with other queer experiences. Our culture sends very overt messages centered around monocentric values, such as the idea of meeting "the one." Furthermore, only monogamous relationships can be recognized legally. Because of these messages, people tend to have negative views of polyamorous relationships, which often makes coming out as poly difficult. Poly folks often experience family disapproval or refusal to acknowledge more than one partner.

---

[1] PrEP is also commonly used by queer male couples who are monogamous and serodiscordant, where one partner is HIV-negative and the other is HIV-positive.

Therapists are not immune to these monocentric social messages and often have self-of-the-therapist work to do to provide ethical care for poly relationships. Therapists may need to examine their internalized monocentric beliefs around infidelity (which is nonconsensual) and explore how these feelings and judgments may come up in work with poly relationships (which are consensual). Henrich and Trawinski (2016) suggest that therapist bias stems from at least three sources: cultural conditioning that favors monogamy, lack of exposure to poly relationships, and issues with infidelity in therapists' private lives.

If people in poly relationships pursue therapy for assistance with constructing their agreement, there are a number of topics that may be discussed. For starters, what kind of relationships can each person pursue? Is there a primary/secondary hierarchy, and if so, what does that mean? What is expected in terms of safer sex practices, and will some partners be "fluid bonded" (allowed to have unprotected sex)? How will time spent with other people be managed, and how are overnights negotiated and scheduled? Are there any special places, activities, or sex acts reserved for one partner? Does one partner get to preapprove or veto another partner's choices? Do partners want to meet other people with whom their partner is involved? How is social overlap managed, or how are choices made about creating boundaries to avoid social overlap? Are there boundaries around personal information that is shared with other partners? What is the plan if the agreement is not working?

Bi-Negativity and Bi-Including Couples

For the purpose of this chapter, I use the term "bisexual," though I acknowledge that other sexual orientation labels closely relate to this term. For example, some people instead identify as "pansexual," being attracted to a person rather than a particular gender category, and feel that this term provides more flexibility for thinking outside the gender binary. Other people might simply identify as queer, enjoying the connection it provides to other queer people or appreciating the vagueness that "queer" can embody. Most of the literature and research has used the term "bisexual," though many people who are attracted to more than one gender (i.e., pansexuals, queer people) also likely identify with many of these experiences and dynamics.

Minority stress for bisexual people seemingly comes from all angles. They are impacted by both "heterosexism" (the assumption that everyone is heterosexual, and that heterosexuality is superior to other sexualities) and "monosexism" (the belief that people can or should only be attracted to and engage in relationships with one sex and/or gender), as well as biphobia (Flanders, Robinson, Legge, & Tarasoff, 2016). Another aspect of bi-negativity which contributes is "bi-erasure," the overlooking or dismissal of bisexuality as an identity. For example, bisexual people are often included in the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) acronym, but their unique experiences are rarely discussed. Also, the sexual orientation of bisexual people is often assumed to be gay or straight, depending on the relationship they are in. In other words, if a bisexual man is in a relationship with a man, he is assumed to be gay, and if he is in a relationship with a woman, he is assumed to be heterosexual.

Another complicating factor for bisexual people is that they often partner with someone who does not also identify as bisexual, making it likely that they find themselves in a mixed-orientation relationship. When this is the case, if the non-bisexual partner's feelings and opinions about bisexuality are negative, they have the potential for causing harm in the relationship. Bisexuals have reported that romantic partners are sometimes negative, discouraging or denying their bisexual identity, and can leave bisexual partners feeling misunderstood (Flanders et al., 2016). Li, Dobinson, Scheim, and Ross (2013) found that bisexuals described rejection from both heterosexual and lesbian/gay partners, describing lesbian and gay partners as having a lack of trust in bisexuals. They described heterosexual women feeling uncomfortable with a male partner who is also attracted to men and heterosexual males objectifying bisexual female partners. In general, they described increased jealousy about the bisexual partner straying from the monogamous relationship in order to have sex with a person of another gender.

Because this bi-negativity can be present in couple relationships, bisexual partners may sometimes compromise their bi-identity to appease a partner who feels threatened by bisexuality (Niki, 2018). Furthermore, bisexual partners can feel silenced by the biphobia of a partner, feeling pressure to redefine as gay or straight. Sometimes this manifests as a bisexual partner only being allowed to reference sexual desires or refer to past lovers that involve a gender the monosexual partner does not feel threatened by (Niki, 2018). For example, a bisexual woman in a relationship with a lesbian may not be permitted to discuss attractions to men or former relationships with men, erasing a part of herself. It is a common insecurity for monosexual partners to feel unsure of their ability to hold the interest of their bisexual partner, feeling they cannot satisfy them sexually or emotionally (Niki, 2018). For example, a bisexual partner may be accused of cheating when they have not behaved in a way that suggests infidelity. This may put the bisexual partner on the defensive, contributing to escalated conflict in the couple, or the bisexual partner may need to spend a lot of energy reassuring the insecure partner.

Negative attitudes toward bisexuality are sometimes also held by bisexual partners and can impact couples' sexual and relationship satisfaction. Mark, Vowels, and Bunting (2020) found that in male–female bi-including couples, when bisexual partners perceived their bisexual identity as illegitimate, both partners reported lower sexual and relationship satisfaction. The heterosexual partner's attitudes toward their partner's bisexuality were not measured, so it is unclear how the heterosexual partner's attitudes might have impacted the bisexual partner's attitudes. As described earlier, the nonbisexual partner sometimes expresses negative beliefs about bisexuality, which may also negatively impact how the bisexual partner views their own identity.

There is some evidence that positive attitudes toward bisexuality may positively impact couples. Mark and colleagues (2020) found that when the bisexual partner felt that their bisexual identity enabled greater intimacy (i.e., being able to understand their partner better sexually), both partners reported higher sexual satisfaction. As therapists, we must be curious about couples' attitudes toward bisexuality and how they may be manifesting in bi-including couples in therapy. Crofford (2018) offers useful suggestions for bisexual inclusive couple therapy, first encouraging therapists to be careful not to assume sexual orientation based on the gender presentation of the couple. This can contribute to bi-erasure, overlooking bisexuality as a valid identity. Furthermore, therapists should address bisexuality directly with both partners. Bisexual partners should be asked what the identity means to them and about any experiences with bi-negativity or bi-erasure. This helps identify minority stress and any related trauma. Monosexual partners should be asked about their attitude toward bisexuality, which can help to identify how bi-erasure may be occurring within the couple relationship (Crofford, 2018).

Dysphoria and Affirmation in Trans-Including Couples

Trans people, perhaps even more than other queer people, experience identity invalidation on a regular basis. For binary trans people (those who identify as female or male), common messages include "You can't just choose a gender," "You will never be a real woman/man," or "You are not trans enough." For nonbinary trans folks, who are almost always misgendered, messages include "You do not exist," "It is not possible to not have a gender," or "You are really just your assigned gender." Because this invalidation is so pervasive and often triggers dysphoria, being affirmed within a couple relationship is even more important. In order to be affirming, cisgender partners can acknowledge the trans partner's identity as valid or real, validate that they are worthy of love, avoid gendered language for nonbinary partners, acknowledge and correct their own and others' microaggressions, educate self on trans identities, and be an ally to the trans community (Galupo, Pulice-Farrow, Clements, & Morris, 2018).

While a cisgender partner's affirmation of their trans partner is important in all settings, it can perhaps be most vital within the sexual relationship of the couple. Dysphoria can cause a person to have a disconnect between body and mind (Martin & Coolhart, 2019), making it difficult for a person to connect to their own body and/or to let another person connect to their body. For example, genital discomfort can lead to withdrawal from sex (Iantaffi & Bockting, 2011). This can be frustrating for both partners, when the trans partner is sometimes unable to enjoy their sexuality or may feel guilt about not giving their partner access to their body. The cisgender partner may feel like they are failing, not being able to please their partner, or feel afraid that they will cause their partner distress if they try to initiate sex. Addressing and navigating this dysphoria within the couple's sexual relationship is necessary in order to increase intimacy and improve sexual satisfaction. Again, the cisgender partner can actively work to affirm their trans partner's identity, which can positively influence the relationship between gender and sexuality, increasing the trans partner's self-esteem (Schilt & Windsor, 2014).

Martin and Coolhart (2019) explored trans masculine experiences of dysphoria and sexuality and found that body dysphoria is often an obstacle or challenge during sexual experiences. Trans partners discussed the importance of communication, where it is important for cisgender partners to have regular "check-ins" to discuss sexual wants, needs, and desires. This allows the trans partner to describe what is okay (touching in certain places or in a certain way) and what is not okay (avoiding touch in certain areas or avoiding certain kinds of touch). One trans partner said, "You cannot go at this like it's a female body. Because it's not and it doesn't feel good. And so understand that it's traumatizing" (Martin & Coolhart, 2019, p. 90). The word "traumatizing" is important here, emphasizing how painful these experiences of dysphoria can be. To protect the trans partner from this level of pain, setting boundaries can be helpful, such as keeping the lights off or always wearing a binder during sex (Martin & Coolhart, 2019).

Some authors have described the importance of open conversations about gender dysphoria and how they can help the couple feel more secure in their relationship (Iantaffi & Benson, 2018). However, it can also sometimes feel like a burden for trans partners to always have to discuss gender dysphoria. In our research, trans partners described these conversations as heavy (not sexy) and sometimes awkward and reported occasionally compromising their sexual satisfaction (such as allowing dysphoric touch to occur) in order to please their partners (Martin & Coolhart, 2019). Therapy can be helpful for trans-including couples in order to provide a space to have these difficult conversations, so that trans partners are not put in positions of having to choose between pleasing their partner and experiencing sexual safety.

Another strategy trans-including couples can use to reduce gender dysphoria during sexual experiences focuses on decentering gendered language for sexual anatomy (Iantaffi & Benson, 2018). Using terms that commonly match the assigned gender may be traumatizing and potentially intensify dysphoria. Trans men typically don't identify with the words "clitoris," "vagina," or "breasts," as these words are associated with femininity and their use could cause dysphoria. Instead, trans men may recode their bodies with terminology that matches their identity, such as "penis," "front hole," and "chest" (Martin & Coolhart, 2019). Again, this shift in language serves to affirm the trans partner in their identity and may increase access to sexual satisfaction.

The prior discussion applies primarily to trans-including couples including a cisgender partner. Sometimes, trans people can and do partner together, which may create another set of unique relationship dynamics. While further research is needed to understand the experiences of trans–trans couples, anecdotally, trans people sometimes describe feeling more at ease with another trans person. Being with a partner who understands the experience of gender dysphoria can contribute to a relaxed feeling, where there is less pressure around performing/proving themselves as their affirmed identity. Thus, not surprisingly, some trans people express a strong romantic/sexual preference for coupling with another trans person.

The Role of the Therapist

Because queer couples often have such pervasive experiences of minority stress, they are inundated with negative messages about the validity, health, and value of their identities, and they experience regular threats to their safety and security. As clinicians, it is imperative that we take a queer-affirmative stance to counterbalance some of this negativity and create safety in the context of therapy. Queer-affirmative therapists assert that no sexual orientation, gender identity, or gender expression is pathological (Keo-Meier & Ehrensaft, 2018), that they are all natural variations of humanity (Coolhart & Shipman, 2017), and that any pathology that is present is a result of homo-/bi-/transphobia, patriarchy, misogyny, and/or sexism, rather than a disturbance in the queer person (Coolhart, 2012; Hidalgo et al., 2013). Queer-affirmative therapists aim to support all gender identities and sexual orientations by gaining education on queer experiences, using inclusive language, normalizing and validating queer experiences, being sensitive to experiences of minority stress and identity-related trauma, and recognizing the strengths and resiliencies queer people have as a result of their queerness.

Because our culture is dominated by cisgender heterosexual experiences, beginning (or even seasoned) therapists often find themselves having little to no exposure to the diversity of coupling described in this chapter. While, of course, we always learn from our clients, it is important that queer clients not feel they are in charge of educating therapists about what it means to be queer. Therefore, therapists need to intentionally expose and educate themselves about queer experiences and relationships. It may be helpful to take a class, attend workshops, and read scholarly articles about queer couples. However, in addition to this more formal education, queer voices are prolific throughout social media, and directly hearing these voices can sometimes be the most powerful source of learning. Thus, consulting popular media sources such as YouTube and Reddit may also be helpful in gaining exposure. In fact, this is the exposure young queer people often report as being instrumental in learning about themselves and how they come to identify within the queer spectrum.

For some therapists, exposure and education may not be enough to come to an affirming stance. For those with deeply embedded homo-/bi-/transphobic beliefs (e.g., from religion or family of origin), it is imperative to consider how these beliefs may be harmful to clients. It is a slippery slope to suggest referring queer clients out to other therapists; the ultimate goal would be for all therapists to learn to be affirming. However, if a therapist ultimately believes that it is abnormal to be gay, trans, nonbinary, consensually nonmonogamous, and so forth, it may be necessary to refer queer couples to avoid causing them harm. However, it should be noted that it is virtually impossible to be a family therapist and avoid queer people altogether, as queer people come out in families across the lifespan. When choosing to refer, clients should be told that they are being referred to a therapist with more experience; because queer people often have negative experiences with providers, they will likely be grateful for being able to avoid yet another.

CASE ILLUSTRATIONS

Marlon and Jake

Marlon and Jake had been a committed couple for 6 years. For the first 2 years of their relationship, Marlon and Jake were monogamous, while they really got to know each other and formed an emotional connection. After 2 years, they agreed that their couple relationship was established and stable enough for them to explore more sexual freedom. They agreed that both were free to have sex with other people, and that they would always use a condom during any outside sex. For 4 years after that, their consensual agreement worked, and Marlon and Jake were happy as a couple, until a breach occurred. A couple of months earlier, Jake had sex with an outside partner and he impulsively didn't use a condom. Afterward, Jake knew he had violated his agreement with Marlon and told him about his slip. This couple entered therapy with me after this breach to repair the violation in trust.

In the beginning of therapy, we explored Marlon's feelings of anger and broken trust. Jake was remorseful, able to take responsibility, and expressed his love and commitment to Marlon. We then explored the other aspects of their agreement and they described that because outside partners could not overlap with their life as a couple, there was no sex with anyone in their social circles including friends and former partners. They were also not to bring outside partners to special places they shared, and there was to be no emotional connection to outside partners. I explored how these other aspects of their agreement were followed and how that felt, particularly for Marlon. Marlon was able to access feelings of security and appreciation for the respect Jake showed to their relationship by honoring the other aspects of their commitment.

While Marlon's feelings of trust were being restored, he couldn't help but have a lingering feeling of unsafety. He wasn't angry anymore about Jake's slip, but he thought, "What if it happens again?" Both Jake and Marlon were HIV-negative, and Marlon feared becoming infected. I explored this fear and discovered that Marlon's fear was particularly strong due to his cultural context and experiences of losing people to HIV. Marlon was 45 years old and grew up in an impoverished Black neighborhood. As a young person, Marlon experienced rejection in his family because of his sexuality, so he didn't talk about it at home, and sought refuge in the underground gay community in his neighborhood. During his 20s, Marlon knew several people who became infected with HIV, didn't have access to health care, became very sick, and died. These memories haunted Marlon, and he feared for Jake's safety as well as his own.

As Marlon shared his painful memories of loss in his neighborhood, Jake seemed anxious. I asked Jake about his feelings, which led to a discussion of the differences in their backgrounds. Jake was White, raised in a middle-class family, and his anxiety in hearing Marlon's memories stemmed from not being able to relate and feeling guilt for his privilege. As a White therapist, I acknowledged the vulnerability Marlon demonstrated in being able to share his pain with two White people. I also believed that my being White contributed to Jake being able to tolerate me challenging about a topic he rarely discussed. After processing Jake's feelings, he became more open to really listening to Marlon and he was able to validate Marlon's feelings.

I then asked about the couple's views on PrEP. Both were knowledgeable about the effectiveness of PrEP but hadn't really considered it in their relationship because there previously had been no need for it. Through discussion, Marlon came to the realization that he would feel safer if Jake would take PrEP, and Jake was very willing to do that to further restore the security in the relationship.

Elizabeth and Mariana

Elizabeth and Mariana, together for 10 years, came to therapy when Mariana discovered that Elizabeth was bisexual. The couple was in conversation and a reference was made to Elizabeth's high school boyfriend. Mariana was quick to say that he wasn't a real boyfriend, that he was just a prop to conceal Elizabeth's lesbian identity. Elizabeth corrected Mariana, stating that she did have feelings for her high school boyfriend. At that point, Mariana "accused" Elizabeth of being bisexual, and Elizabeth admitted that she did think of herself as bisexual. Elizabeth had never disclosed her bisexuality before because she planned to be monogamous with her partner, so it didn't seem important. She also feared how her partner would react.

Mariana felt betrayed and lied to, and her anger was expressed through bi-negativity. She said things like, "The thought of you having sex with a man disgusts me" or "If you ever have a penis in your mouth, I don't think I could ever kiss you again." Elizabeth felt hurt and silenced by these messages, causing her to withdraw, making Mariana even angrier. In therapy, we first addressed this interactional pattern. I told Mariana that her feeling of betrayal was valid and that we would definitely explore more about her experience, but that right now, we were losing Elizabeth in this conversation. I asked Elizabeth what was happening for her when Mariana was expressing her anger, and Elizabeth shared feelings of being hurt by the cruel comments about her sexuality. I asked Elizabeth what her bisexuality meant to her, and she shared that she really didn't care about a partner's gender, that she really just loves a person for who they are. While I had to continue to calm Mariana and assure her that we would get to her feelings, she was progressively more able to listen to Elizabeth.

Elizabeth described feeling hurt when Mariana sexualized her way of loving with such crudeness. She described internalizing some of these feelings and said that she sometimes feels like she is disgusting. Elizabeth said that she knew Mariana saw her as disgusting, so she had stopped being physically close with Mariana. Mariana was concerned that she was hurting her partner in this way, so she became more engaged. Mariana acknowledged that she could understand that equating sexual orientation with sex acts could be hurtful, as that is how her mother responded when she came out as lesbian. Her mom expressed disgust about oral sex between women, and Mariana understood how that can get internalized. Elizabeth agreed that this kind of message was common in their cultures. Elizabeth and Mariana are Latinx, Elizabeth of Mexican descent and Mariana of Colombian descent.

We explored Elizabeth's and Mariana's experiences of cultural messages around being bisexual and lesbian. The two women were able to connect on many of their common experiences and messages they received about their sexuality, including the strong use of the Bible in their cultures to condemn queer sexuality. Mariana acknowledged that the messages she received in her culture communicated that bisexuality wasn't a "real" sexuality and that people were either straight or gay. I asked if it was possible that this message got internalized just as the homo-negativity was internalized at another point in her life. Through this exploration, Mariana was able to see the way in which her anger was coming out as bi-negativity. She was able to acknowledge that it was not right for her to attack an aspect of Elizabeth's identity.

As Mariana was able to process some of her bi-negativity, her feelings of anger and betrayal became diffused, as she understood why it was difficult for Elizabeth to share her bisexual identity with her. This shift left space for other feelings Mariana had about Elizabeth's bisexuality. Mariana began to experience anxiety about Elizabeth cheating on her with a man, or worse, leaving her for a man. She felt as though there was no way she could be enough for Elizabeth given that she literally didn't have what attracted Elizabeth. I validated that it is common for partners of bisexuals to experience that feeling, and we co-identified the feeling as fear of losing Elizabeth's commitment. In therapy, I facilitated a conversation about Mariana's fear and Elizabeth responded with reassurance. Elizabeth confirmed her monogamous commitment to Mariana and reiterated that her bisexuality is about loving a person, and that person is Mariana. I normalized that Mariana's fear might come up at times, and we discussed what was most comforting for Mariana to hear in those moments; Elizabeth agreed to try and respond with those messages going forward.

As a therapist who identifies as bi/pansexual and has experienced bi-negativity, I had to be very aware of how this aspect of my identity was impacting my relationship with Elizabeth and Mariana. On the one hand, because of my personal experience with bi-negativity, I was able to pick up on the nuances of messages that were being communicated. On the other hand, I had to manage my reactivity around feeling a sting from Mariana's words, being sure to stay centered and present for both partners. As a White therapist, I wasn't familiar with all the nuances of the cultural messages Mariana and Elizabeth experienced, though I was able to hold space for the women to share and connect through their shared experiences as Latinx queer women.

Lydia and Shayne

Lydia and Shayne have been together for 15 years. They got together before Shayne realized he was a trans man, and he socially and medically transitioned about 3 years ago. Lydia supported Shayne's transition but struggled with what it meant for her sexual identity. She had previously identified as a lesbian but no longer felt that the label fit for her relationship. After some time, Lydia began to embrace Shayne's new identity, use his name and pronouns, and discover a new attraction for his masculinized body. However, since transition, Shayne and Lydia's sex life has been strained. Their typical sexual encounter is as follows: Shayne initiates and pleases Lydia, Lydia attempts to please Shayne, Shayne shuts down, Lydia feels rejected, and neither is sexually satisfied. As a result, both partners feel afraid to initiate sex.

In therapy, we explored what was happening during this pattern of sexual initiation that eventually led to sexual dissatisfaction. Lydia described feeling confused because after Shayne's transition, he began to initiate sex more often, but then when they were in the act, he would become disengaged and seemed to dissociate. Shayne described that while his sex drive had gone up since starting to take testosterone, leading him to initiate sex, he described getting lost in his head during sex. As we discussed his history, he described always feeling a little off about sex but being able to push through and do what he was supposed to do. Since coming into himself as a trans man, he said the "feeling off" has increased to a feeling that is debilitating, paralyzing him in the situation. When I asked about Shayne's experience of gender dysphoria, he talked about feeling extreme dysphoria when first realizing his maleness and much of the dysphoria getting better after testosterone and top surgery (masculinizing chest reconstruction). He still struggled with social dysphoria, due to not always being gendered correctly, and reported a lot of bottom dysphoria (dysphoria with genitals).

Engaging Lydia in the conversation, I asked if she was aware of Shayne's social and bottom dysphoria. She reported being sort of aware of it through observing his social anxiety and his shyness around her seeing his genitals but reported that they hadn't really talked about it. Shayne reflected that he felt like his dysphoria was a burden and didn't want to put that on Lydia. He also described assuming that she wouldn't understand, since she is cisgender. I disclosed that I am also cisgender and, while I can't know what dysphoria feels like firsthand, I have learned a lot about dysphoria through my years of talking about it with trans people. I suggested Lydia might be capable of learning, too, if he could talk with her about it. Lydia expressed wanting to understand more, and Shayne, somewhat reluctantly, agreed to talk about it (he reported struggling in general to talk about feelings).

As we further discussed the current pattern around Lydia and Shayne's sexual encounters, Shayne was able to describe how dysphoria got in the way during sex. He explained that Lydia didn't really change her sexual behaviors toward him since his transition, and that made him feel like Lydia didn't really see him as a man. Additionally, there were particular acts that made his dysphoria spike, including penetration and sometimes oral sex. Before discussing further, I asked Shayne if there was particular language for his "parts" that felt more or less comfortable. He described hating the terms "clitoris" and "vagina" because they were too feminine, but not knowing what to call them. I encouraged him to call them whatever he wanted and encouraged Lydia to use this language in order to affirm Shayne's masculinity/maleness. He decided on "my little man" and "front hole," and reported that those terms felt more comfortable.

As the therapy process progressed, we identified the specific instances during sex that caused dysphoria and explored new ways to express and explore. Lydia learned that the "front hole" was closed for business until further notice. Shayne said that there might be occasions where he would desire penetration and he would ask for it, but that it needed to be considered off limits for him to feel safe. Lydia also learned how to orally stimulate Shayne's "little man" in ways that Shayne experienced as masculine. Additionally, we discussed how the couple could better monitor dysphoria's level of activation during sex in a collaborative way, where both partners were responsible. They agreed that Lydia could say, "You with me, babe?" and if Shayne was feeling dysphoric, he would respond with "No" or "I'm fading." Shayne agreed to try to recognize dysphoria sooner and say, "Code red," if it was starting to get in the way. In the event of a code red, the couple agreed to stop all genital contact and reground together through other forms of physical connection, such as hugging, cuddling, kissing. Shayne also added that it would be helpful for Lydia to affirm his masculinity/maleness during those moments by saying something like, "Look at this gorgeous flat chest, you sexy man" or, "I love how strong your arms are."

Finally, we explored other ways in which Shayne felt like he needed affirmation from Lydia outside of sex. Shayne described experiencing anxiety around cisgender men, feeling like he didn't know how to interact with them, and that he was not man enough. For example, when a contractor came to the house, he froze in anxiety and pulled Lydia in to deal with it, even though Shayne was the one with the more specialized knowledge of the project. Lydia was angry, feeling like she was left with the primary responsibilities in the relationship. Shayne expressed that he just needed Lydia to be there when he talked to contractors, serving as a supportive presence in a situation that was uncomfortable and dysphoria-inducing. When Lydia further understood how dysphoria was the problem in these situations and that just her presence could make a difference, she was happy to support Shayne in that way.

In terms of relational intersectionality with my identities as a therapist, I previously described how I used the disclosure of my cisgender identity to encourage discussion between partners about dysphoria. Another intersection in this case was that the clients and I are White. Our shared Whiteness was not discussed in relation to the couple's challenges; however, it was important while talking about larger surrounding social issues. At the time that I saw this couple, George Floyd was murdered and the Black Lives Matter movement was very active. The couple discussed with me their feelings about the movement, including helplessness around what they could do to help as White people. Our discussion evolved into what we need to do as White people is to bring the message of dismantling White supremacy back to our communities; we also discussed ideas for how we could do this.

CONCLUDING COMMENTS

Because queer couples experience invalidation and mistreatment in many aspects of their lives, being able to see an affirmative therapist may be felt as a real relief. Becoming an affirmative therapist takes intentionality around gaining education and commitment to staying up to date with evolving language and identities. Additionally, a relational intersectional lens is essential in order to understand how queer identities are experienced simultaneously with other social locations and how therapists' social locations also impact therapy. When therapists are able to work from these foundations, they will only grow as a result of working with the vast diversity and tremendous creativity present under the umbrella of queer couples.

SUGGESTION FOR FURTHER STUDY

Harvey, R., Murphy, M. J., Bigner, J. J., & Wetchler, J. L. (2021). *Handbook of LGBT-affirmative couple and family therapy* (2nd ed.). New York: Routledge.

REFERENCES

Addison, S., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54,* 435–453.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology, 17,* 163–174.

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29,* 258–269.

Biaggio, M., Coan, S., & Adams, W. (2002). Couples therapy for lesbians: Understanding merger and the impact of homophobia. *Journal of Lesbian Studies, 6,* 129–138.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies, 7,* 87–108.

Combahee River Collective. (1977). *A Black feminist statement*. Boston: Author.

Conley, T. D., Moors, A. C., Matsik, J. L., & Ziegler, A. (2012). The fewer the merrier?: Assessing stigma surrounding consensually nonmonogamous romantic relationships. *Analyses of Social Issues and Public Policy, 13,* 1–30.

Connolly, C. M. (2012). Lesbian couple therapy. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 43–56). New York: Routledge.

Connolly, C. M., & Sicola, M. K. (2005). Listening to lesbian couples: Communication competence in long-term relationships. *Journal of GLBT Family Studies, 1,* 143–167.

Coolhart, D. (2012). Supporting transgender youth and their families in therapy: Facing challenges and harnessing strengths. In J. Bigner & J. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy*. New York: Routledge.

Coolhart, D., & Shipman, D. L. (2017). Working towards family attunement: Family therapy with transgender and gender nonconforming children and adolescents. *Psychiatric Clinics of North America, 40,* 113–125.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43,* 1241–1299.

Crofford, M. L. (2018). Bisexual inclusive couples therapy: Assessment and treatment with bisexuals in mixed orientation relationships. *Sexual and Relationship Therapy, 33,* 233–243.

Esmail, A. (2010). "Negotiating fairness": A study on how lesbian family members evaluate, construct, and maintain "fairness" with the division of household labor. *Journal of Homosexuality, 57,* 591–609.

Fierman, D. M., & Poulsen, S. S. (2011). Open relationships: A culturally and clinically sensitive approach. *American Family Therapy Academy Monograph Series, 7,* 16–24.

Flanders, C. E., Robinson, M., Legge, M. M., & Tarasoff, L. A. (2016). Negative identity experiences of bisexual people: A qualitative report. *Journal of Gay and Lesbian Mental Health, 20,* 152–172.

Galupo, M. P., Pulice-Farrow, L., Clements, Z. A., & Morris, E. R. (2018). "I love you as both and I love you as neither": Romantic partners' affirmations of nonbinary trans individuals. *International Journal of Transgenderism, 20*(2/3), 1–12.

Gates, G. J. (2012). *Same-sex couples in Census 2010: Race and ethnicity*. Los Angeles: The Williams Institute.

Glass, V. Q., & Few-Demo, A. L. (2013). Complexities of informal social support arrangements for Black lesbian couples. *Family Relations, 62,* 714–726.

Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships: Mathematical modeling of conflict interaction. *Journal of Homosexuality, 45,* 65–91.

Green, R.-J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues in couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed.). New York: Guilford Press.

Hamilton, C. J., & Mahalik, J. R. (2009). Minority stress, masculinity, and social norms predicting gay men's health risk behaviors. *Journal of Counseling Psychology, 56,* 132–141.

Hartwell, E. E., Serovich, J. M., Reed, S. J., Boisvert, D., & Falbo, T. (2017). A systematic review of gay, lesbian, and bisexual research samples in couple and family therapy journals. *Journal of Marital and Family Therapy, 43,* 482–501.

Hatzenbueler, M. L., Nolen-Hoeksema, S., & Erickson, S. J. (2008). Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men. *Health Psychology, 27,* 455–462.

Henrich, R., & Trawinski, C. (2016). Social and therapeutic challenges facing polyamorous clients. *Sexual and Relationship Therapy, 31,* 376–390.

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56,* 285–290.

Iantaffi, A., & Benson, K. (2018). Sex is for every body: Trans-affirming sex therapy. In D. Flemons & S. Green (Eds.), *Quickies: The handbook of brief sex therapy* (pp. 196–215). New York: Norton.

Iantaffi, A., & Bockting, W. O. (2011). Views from both sides of the bridge?: Gender, sexual legitimacy and transgender people's experiences of relationships. *Culture, Health and Sexuality, 13,* 355–370.

Kelly, M., & Hauck, E. (2015). Doing housework, redoing gender: Queer couples negotiate the household division of labor. *Journal of GLBT Family Studies, 11,* 438–464.

Keo-Meier, C., & Ehrensaft, D. (2018). Introduction to the gender affirmative model. In C. Keo-Meier & D. Ehrensaft (Eds.), *Perspectives on sexual orientation and diversity. The gender affirmative model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 3–19). Washington, DC: American Psychological Association.

Kimmel, S. B., & Mahalik, J. R. (2005). Body image concerns of gay men: The roles of minority stress and conformity to masculine norms. *Journal of Consulting and Clinical Psychology, 73,* 1185–1190.

Kurdek, L. A. (2008). Change in relationship quality for partners from lesbian, gay male, and heterosexual couples. *Journal of Family Psychology, 22,* 701–711.

LaSala, M. C. (2005). Monogamy of the heart. *Journal of Gay & Lesbian Social Services, 17,* 1–24.

Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology, 79,* 159–170.

Li, T., Dobinson, C., Scheim, A. I., & Ross, L. E. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lives lived. *Journal of Gay and Lesbian Mental Health, 17,* 21–39.

Malone, J., Syvertsen, J. L., Johnson, B. E., Mimiaga, M. J., Mayer, K. H., & Bazzi, A. R. (2018). Negotiating sexual safety in the era of biomedical HIV prevention: Relationship dynamics among male couples using pre-exposure prophylaxis. *Culture, Health and Sexuality, 20,* 658–672.

Mark, K. P., Vowels, L. M., & Bunting, A. M. (2020). The impact of bisexual identity on sexual and relationship satisfaction of mixed sex couples. *Journal of Bisexuality, 20,* 119–140.

Martin, T. K., & Coolhart, D. (2019). "Because your dysphoria gets in the way of you . . . it affects everything": The mental, physical, and relational aspects of navigating dysphoria and sex for trans masculine people. *Sexual and Relationship Therapy, 37,* 82–99.

McEachern, M., Coolhart, D., & Watson, D. (2022). Therapy with queer women couples: Multiracial feminist therapy considerations. In R. Harvey & M. Murphy (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (2nd ed.). New York: Routledge.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36,* 38–56.

Niki, D. (2018). Now you see me, now you don't: Addressing bisexual invisibility in relationship therapy. *Sexual and Relationship Therapy, 33*(1–2), 45–57.

Perel, E. (2006). *Mating in captivity: Unlocking erotic intelligence.* New York: HarperCollins.

Perlesz, A., Power, J., Brown, R., McNair, R., Schofield, M., Pitts, M., & Bickerdike, A. (2010). Organizing work and home in same-sex parented families: Findings from the work love play study. *Australian and New Zealand Journal of Family Therapy, 31,* 374–391.

Rostosky, S. S., & Riggle, E. D. B. (2017). Same-sex relationships and minority stress. *Current Opinion in Psychology, 13,* 29–38.

Schilt, K., & Windsor, E. (2014). The sexual habitus of transgender men: Negotiating sexuality through gender. *Journal of Homosexuality, 61*(5), 732–748.

Szymanski, D. M., & Chung, Y. B. (2001). The Lesbian Internalized Homophobia Scale: A relational/theoretical approach. *Journal of Homosexuality, 41,* 37–52.

Szymanski, D. M., Chung, Y. B., & Balsam, K. F. (2001). Psychosocial correlates of internalized homophobia in lesbians. *Measurement and Evaluation in Counseling and Development, 34,* 27–38.

Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A. R., & Updegraff, J. A. (2000). Behavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review, 107,* 411–429.

Totenhagen, C. J., Randall, A. K., & Lloyd, K. (2018). Stress and relationship functioning in same-sex couples: The vulnerabilities of internalized homophobia and outness. *Family Relations, 67,* 399–413.

Tunnell, G. (2012). Gay male couple therapy: An attachment-based model. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT couple and family therapy* (pp. 25–42). New York: Routledge.

COUPLE-BASED THERAPY FOR INDIVIDUAL PROBLEMS

CHAPTER 24

Couple Therapy for Posttraumatic Stress Disorder

Candice M. Monson and Steffany J. Fredman

Posttraumatic stress disorder (PTSD) is a prevalent and pernicious disorder that has well-documented associations with intimate-relationship problems, including increased relationship distress, emotional intimacy problems, and partner aggression and violence (for reviews, see Monson, Fredman, Dekel, Ennis, & Macdonald, in press; Taft, Watkins, Stafford Street, & Monson, 2011). In addition, PTSD in one intimate partner has been linked with psychological problems and caregiver burden in the other partner (Lambert, Engh, Hasbun, & Holzer, 2012). With recognition of these factors, as well as the inherently relational aspects of traumatization and the potency of interpersonal relationship factors in trauma recovery (for a review, see Wagner, Monson, & Hart, 2016), there have been efforts to develop couple/family interventions for PTSD. In this chapter, we present a disorder-specific conjoint therapy for PTSD—cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD; Monson & Fredman, 2012)—which has demonstrated efficacy for ameliorating PTSD, with the additional benefits of enhancing intimate-relationship functioning and improving the health and well-being of intimate partners.

BACKGROUND

Historically, the treatment of PTSD has been conceptualized and approached from an intrapersonal (individual) perspective. There are various possible reasons for this—including the fact that PTSD was not recognized as a diagnostic entity until 1980, when biological formulations of psychopathology and psychopharmacology were predominant, and psychotherapy theory and practice focused on individual factors. Concerns about the possibility of "vicarious" or "secondary" traumatization if trauma survivors spoke about their traumatic experiences to fellow survivors or loved ones also likely contributed to individually based approaches to treatment. At the same time, there was increasing recognition that a negative interpersonal environment was associated with worse outcomes for individual treatment (Tarrier, Sommerfield, & Pilgrim, 1999), whereas social support was one of the factors most consistently and robustly associated with whether an individual would have PTSD after trauma exposure (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, Tami, & Weiss, 2003).

At the time that one of us (CMM) was developing CBCT for PTSD in the early 2000s within the U.S. Department of Veterans Affairs health care system, there were two other salient factors influencing its creation. First, the clinical *Zeitgeist* surrounding PTSD was that it is a chronic disorder and that the most appropriate treatment is palliative in nature. Medication, skills-focused psychosocial interventions to facilitate coping with the symptoms, and supportive therapy were the mainstay treatments. Although trauma-focused cognitive-behavioral therapies were being developed and tested with female sexual assault victims in the community, these innovations were not widely accepted or practiced with veterans. In fact, at least one negative trial of exposure therapy with veterans evidencing symptom exacerbations was used to argue against such therapy (Pitman et al., 1991). A second factor influencing the development of CBCT for PTSD was that several uncontrolled and controlled trials of general behavioral couple/family therapy had been conducted by then, showing modest improvements in relationship functioning but little to no effect on PTSD symptoms (e.g., Glynn et al., 1999).

Recognizing that most of the veterans with PTSD we were treating had not been offered a course of trauma-focused cognitive-behavioral therapy and were presenting because of relationship problems, we sought to develop a therapy that included the cognitive and behavioral PTSD interventions shown to be efficacious at that time for nonveterans. These interventions included imaginal exposure (i.e., having a client review the trauma memory repeatedly until the anxiety surrounding it decreases) and *in vivo* exposure (i.e., systematically having the client face present-day avoided trauma reminders until the anxiety surrounding them decreases). In addition, cognitive interventions (e.g., questioning by the therapist about dysfunctional thoughts and having clients completing worksheets to challenge their own thoughts) aimed at problematic trauma appraisals and resulting beliefs were being used.

At about this time, the evidence base for cognitive theories of PTSD and related interventions was growing (Ehlers & Clark, 2000; Resick, Nishith, Weaver, Astin, & Feuer, 2002). Cognitive approaches to trauma processing do not require immersion in the trauma memory until anxiety habituates; rather, the trauma is discussed in enough detail to appropriately contextualize the memory and make healthier meaning of the experience and its implications. Anecdotal experience and empirical data demonstrated that this approach to trauma processing was amenable to the couple format, that it resulted in improvement in both PTSD symptoms and relational functioning, and that the level of trauma disclosure required for this method was not unduly distressing for the person with PTSD or the partner.

Noting the findings for general couple therapy for PTSD, and following in the tradition of developers of disorder-specific couple therapies for various mental health conditions (Baucom, Shoham, Meuser, Daiuto, & Stickle, 1998; see also Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), we found it was important to create an intervention that could not only address relationship factors but also take into account the unique aspects of PTSD in relational functioning. From the literature, we expected the modal couple to be distressed or to have structured their relationship in such a way as to maintain the symptoms of the disorder (i.e., "accommodation," discussed in more detail below). In this vein, we drew from systemic notions of couple/family therapy, appreciating that relationship problems and partner functioning could contribute to the onset of PTSD and impede recovery after traumatization, as well as the fact that PTSD symptoms could erode relational and individual partner functioning. Finally, we purposefully titled the treatment "conjoint" rather than "couple" because we believed that many of the issues relevant to romantic partners were germane to other dyads (e.g., siblings, parent–adult child) and anticipated its broader application. In fact, we have begun to implement and test the therapy with a range of adult dyads.

As we hope is evident from this brief history of the development of CBCT for PTSD, we sought to take what we knew worked in individually delivered PTSD treatment and integrated it with evidence-based couple interventions to create a single treatment protocol that could efficiently and effectively treat PTSD and enhance relationship functioning. In the nearly two decades of our developing, testing, and now disseminating CBCT for PTSD, it has been gratifying to see the tide turn toward considering the larger interpersonal context of PTSD and the potential for a conjoint therapy to be a stand-alone treatment for PTSD.

CORE UNDERSTANDINGS ABOUT THIS POPULATION

Monson and colleagues (in press) have put forth a cognitive-behavioral interpersonal theory (C-BIT) of PTSD accounting for the association between intimate relationship problems and the onset and maintenance of PTSD. An important tenet of this theory is the notion of "natural" versus "impeded" recovery after trauma exposure. Compared with most mental health conditions, PTSD is not considered to be a disorder that "develops" per se. There is a known pathogen for the condition (i.e., one or more traumatic events), and the preponderance of individuals who are exposed to traumatic events have some distress following exposure. However, this distress abates with time, and they are not later diagnosed with PTSD (e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). A relative minority of individuals exposed to traumatic events do not experience this natural recovery and are diagnosed with PTSD. According to C-BIT, there are individual and relational factors that impede natural recovery. More specifically, we posit behavioral, cognitive, and affective variables that interact within each individual and between members of a dyad to co-create a relationship milieu that, in turn, feeds back on the individuals existing in that milieu. These factors can either facilitate or hinder the natural recovery process.

Behavioral Factors

In behavioral conceptualizations of PTSD, classical conditioning processes account for why certain stimuli associated with trauma later provoke distress; operant conditioning (in particular, the negative reinforcing value of avoidance) accounts for the maintenance of the distress response (Mowrer, 1960). From an interpersonal perspective, partners often modify their behaviors in response to patients' symptoms to decrease the patients' distress or minimize conflict due to PTSD symptoms—a phenomenon we have labeled "partner accommodation of PTSD symptoms" (Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014; also see Reuman & Thompson-Hollands, 2020). Partner accommodation can take many forms, such as colluding in avoidance and safety behaviors, not expressing one's own thoughts or feelings about relationship concerns that may be distressing to patients, not making loud noises to avoid startling a patient, taking over tasks or chores for the patient that they find distressing, or making excuses for the patient's behaviors to others. Couple-level avoidance of places, people, feelings, and situations that the patient finds distressing, poor communication and conflict management skills, and a critical, negative, or otherwise unsupportive intimate relationship milieu can each decrease the likelihood of effective trauma disclosure. As discussed below, this is relevant to trauma recovery because trauma disclosure in an encouraging and supportive environment is thought to facilitate a more cogent trauma narrative and emotional processing of traumatic memories.

Partner accommodation is a response to patient PTSD symptomatology (Allen et al., 2021) and commonly is motivated by a desire to be helpful and/or to maintain relationship harmony (Renshaw et al., 2020). Partner accommodation can negatively affect intimate relationship satisfaction through decreased engagement in shared pleasurable activities (e.g., going to movies), decreased affective expression and intimacy, and limited self-disclosure, including trauma-related disclosure. Such accommodation, thus, has negative implications for patient, partner, and relationship well-being (Campbell & Renshaw, 2018; Fredman et al., 2014, 2016).

Cognitive Factors

Various ways in which individuals and significant others maladaptively appraise traumatic events can lead to posttraumatic symptomatology and intimate relationship problems. These barriers include a variety of social-cognitive constructs, including hindsight bias and its derivatives (e.g., "undoing" the event by thinking about alternative actions that might have prevented the event), "happily-ever-after thinking" (i.e., thinking that an alternative action would have led to a positive outcome), just-world thinking (the belief that good things happen to good people and bad things happen to bad people), and actor–observer biases (i.e., not fully appreciating the situational variables that affect behavior; making characterological attributions about situationally influenced behavior).

In addition to cognitive content that is disturbed with traumatization, there are cognitive process disturbances associated with the onset of PTSD, including attention/concentration deficits and selective attention to negativity (Jacob, Dodge, & Vasterling, 2019). Not uncommonly, selective attention to threat extends to the perceptions of partners' behaviors, such as the suspicion that a partner's intentions toward a traumatized individual are negative. Selective attention to negative relationship behaviors, negative attributions for each other's behaviors, and negative assumptions and expectancies about each other also characterize members of couples experiencing relationship distress more generally (see also Chapter 3, in this volume, by Baucom et al.). Thus, the tendency for partners in couples in which at least one partner has PTSD to view each other as a source of threat is similar to the tendency observed in other distressed couples; it simply tends to be amplified in the presence of PTSD.

Emotional Factors

Research shows that the emotional disturbances associated with traumatization extend beyond anxiety. Individuals experience a range of emotions in addition to fear, including guilt, shame, anger, grief, and sadness (McLean & Foa, 2017, for a review), and avoidance can generalize to the experience and expression of emotions more generally (e.g., Meyer, Morissette, Kimbrel, Kruse, & Gulliver, 2013). According to C-BIT, individuals who experience this range of emotions without trying to escape from them, and who are encouraged by close others to experience and express them, are more likely to have a natural recovery. Expressing the range of emotions creates individual mastery and greater emotion regulation; it can also facilitate intimacy and closeness with others.

THE PRACTICE OF CBCT FOR PTSD

The Structure of the Therapy Process

CBCT for PTSD is a three-phase, 15-session, manualized treatment (Monson & Fredman, 2012), described with the acronym "R.E.S.U.M.E. Living" to convey the sequential treatment phases and to signify the recovery-focused nature of the therapy. The R and E capture the overall goals of Phase 1, which are to provide a Rationale for treatment and to Educate the couple about PTSD and associated interpersonal problems. The S and U stand for the overall goals of Phase 2, which are to enhance relationship Satisfaction and to Undermine the avoidance that maintains PTSD and relationship issues. The M and E represent the overall goals of Phase 3, which are to make Meaning of the traumatic event(s) and to reach the End of therapy (but not the end of using the skills). Sessions are 75 minutes each and include within-session practice and out-of-session assignments to facilitate the couple's skills acquisition outside sessions.

Phase 1 comprises two sessions designed to orient the couple to treatment, increase positive behavior exchanges between partners, and enhance physical and emotional safety in the couple's relationship. In the first session, the therapist provides the couple with a rationale for conjoint treatment, which includes psychoeducation about PTSD and its symptoms in a relational context. To this end, the therapist helps the couple understand how emotional numbing, behavioral and experiential avoidance, and problematic thoughts maintain PTSD, and how PTSD can contribute to relationship difficulties. During this session, therapist and couple collaboratively develop behaviorally specific, couple-level goals with respect to improvements (though not necessarily perfection) in PTSD symptoms and relationship functioning; the couple will work toward achieving these goals over the course of treatment. For out-of-session practice, partners are asked to catch each other doing a nice behavior daily, and each partner is asked to respond to questions about their understanding of the effects of trauma and PTSD on themselves, the relationship, and beliefs in trauma-related domains.

Session 2 focuses on building and enhancing safety in the relationship. Negative relationship behaviors with known adverse effects on relationship satisfaction (e.g., name-calling, sarcasm, and other forms of hostility; threats of physical aggression against one's partner; and threats to end the relationship when one does not necessarily intend to do so) are identified as treatment targets, with the understanding that cessation of these behaviors is an immediate treatment goal. Couples are provided with psychoeducation about dysregulation in the fight-or-flight system as it relates to PTSD and relationship functioning. The therapist assists the couple in identifying relationship-based patterns that occur during conflict (e.g., anger/aggression, withdrawal) and teaches the partners primary prevention strategies (e.g., noticing early warning signs in oneself and one's partner) and secondary prevention strategies (e.g., negotiated time-outs) for managing conflict and intense affect. These skills are also relevant in couples presenting with a pattern of chronic avoidance, where partners learn to "time back in" as a way of engaging with each other and facilitating discussion of important issues.

In Phase 2 (Sessions 3–7), the therapist focuses on enhancing relationship satisfaction and undermining avoidance. Throughout this phase and the subsequent one, the couple engages in dyadic, graduated, trauma-relevant *in vivo* approach assignments that help to "shrink PTSD" by combating behavioral avoidance and decreasing partner accommodation of symptoms. In addition, the couple is taught communication skills that also help to "shrink PTSD" by serving as antidotes to PTSD-related avoidance of emotions and conversations and as opportunities to increase intimacy. Improvements in the ability to identify and share emotions also help to combat PTSD-related emotional numbing. The communication skills presented and practiced in each session build sequentially over several sessions to help the partners identify and share their feelings, notice the ways that their thoughts influence their feelings and behaviors, and observe how their thoughts may affect each other's thoughts and emotions. The couple uses these communication skills to discuss PTSD-related content and to make collaborative decisions to address PTSD-related avoidance by engaging in the opposite behavior (i.e., approaching).

Specifically, in Session 3, the partners use their reflective listening skills to discuss places, people, feelings, and situations that they avoid as a result of PTSD, and what things they would do differently if the role of PTSD in their relationship were smaller. In Session 4, they identify feelings that they each have about the role of PTSD in their relationship, and what other feelings they would have if PTSD took up "less space" in their relationship. Beginning in Session 4, every out-of-session assignment includes a couple-level *in vivo* approach activity to counter the PTSD-related avoidance identified in Session 3. For example, partners who have previously avoided going to movie theaters as a result of PTSD would engage in a series of gradual movie-related activities with increasing intensity at each step (e.g., going to a weekday matinee and sitting in the back of the theater, going to a weekday evening show and sitting in the center of the theater, and ultimately going to a crowded movie on a Saturday night and sitting in the middle of the first row). Thoughts and behavioral impediments that prevent engagement are identified and addressed (e.g., partner thoughts that lead to colluding in safety behaviors; the belief that anxiety is dangerous; that the couple will argue during the activity, and that such conflict will inevitably lead to the end of the relationship; or that the individual with PTSD will become so dysregulated during the activity that they will suffer a stroke or heart attack).

Building on the couple's improved satisfaction, enhanced communication skills, and decreased behavioral avoidance, the third phase of CBCT for PTSD targets trauma-related cognitions. The therapist teaches the partners a collaborative process they can use to challenge cognitions that maintain PTSD and relationship problems (e.g., "Sharing control with my partner is the same thing as having no control in this relationship"). The treatment employs a simple process to challenge cognitions dyadically, rather than using traditional thought records. The goal of the intervention is to increase cognitive flexibility; it might be thought of as cognitive problem solving because it increases the range of possible cognitive solutions to problematic thoughts. We have labeled this dyadic cognitive process the "U.N.S.T.U.C.K." process to convey that the couple is working together to modify "stuck points" (i.e., thoughts either partner holds that maintain PTSD and/or relationship distress).

The steps are as follows. The partners come to the process united as a team and curious about their thoughts (U—United and curious); one member of the couple nominates a thought to be explored by using the U.N.S.T.U.C.K. process (N—Noticed thought); the couple generates a list of alternative thoughts to the noticed thought (S—brainStorming); the couple reviews the alternative thoughts (T—Test them out); the couple selects the most compelling or balanced alternative thought (U—Use the most balanced); the couple observes any changes in emotion or behavior that result from this new, more balanced thought (C—Change in emotions and behaviors); and the couple determines a way to maintain this new way of thinking by continued practice (K—Keep practicing).

The noticed thought, the alternative thoughts generated in response, the balanced thought selected to compete with the original noticed thought, the changes in emotions and behaviors, and the ideas to keep practicing the new thought are recorded on a sheet entitled the "Big Picture" sheet. This is in keeping with the notion that although PTSD and/or relationship distress cause partners to think in a rigid, myopic manner, by working together, the partners can think more flexibly about the traumatic event(s) and their relationship by taking a broader, "big picture" perspective.

Cognitions targeted in this phase are sequenced with an initial focus on historical cognitions specific to the traumatic event (e.g., acceptance, blame), followed by a focus on interpersonal beliefs disrupted by the trauma (e.g., trust, control, emotional closeness, physical closeness). This order was chosen because changes in the ways in which the couple makes meaning of the trauma can affect consequent beliefs about the present and future. If trauma-specific cognitions are targeted first, there are cascading effects on maladaptive beliefs about the present and future.

The protocol includes a session on the potential for finding benefit in experiencing the trauma and posttraumatic growth (e.g., "We are closer as a couple as a result of surviving this trauma together and participating in treatment together"). The therapist discusses how the couple can move forward by continuing to practice the skills, with the goal of creating a better life together. Treatment gains are identified and consolidated in the final session, and the likelihood of fluctuations over time in relationship satisfaction and perhaps in trauma-related symptomatology is predicted, with a focus on what the partners will do if such fluctuations occur.

We expect that by the end of the 15-session CBCT for PTSD protocol, most couples will have exhibited significant reductions in PTSD symptomatology and gains in relationship functioning, but there may still be room for further progress toward these goals. We highlight for couples that they are equipped with the skills needed to consolidate these gains, and we predict for them that with continued implementation of their skills, they will experience further improvements. Therapists have the option to schedule a check-in or booster session with a couple about 3 months following Session 15. We have found that, for many couples, knowing they will be reporting on their status motivates them to keep up with skills use in the absence of the structure of regularly scheduled sessions.

Given the role of avoidance in maintaining both PTSD and relationship problems, we believe that the time-limited nature of the CBCT protocol is a powerful antidote to PTSD-related avoidance because couples know they must avail themselves of the skills taught in each session to profit fully from the therapy by the end of 15 sessions. We recommend scheduling the first seven sessions (Phases 1 and 2 of the therapy) twice per week to gain traction with the couple, in terms of both combating PTSD-related avoidance and improving the couple's affective milieu; thereafter, sessions can be scheduled weekly. We recognize, of course, that such scheduling may not be possible in all clinical settings, in which case holding sessions once per week is acceptable. However, we strongly advise against scheduling sessions at longer intervals (e.g., biweekly or once per month) because this could reinforce avoidance and undermine the momentum that the couple can achieve with more frequent sessions. If the couple anticipates a break in treatment of more than 2 weeks (due to travel, work constraints, or a medical procedure), we recommend either holding off on starting the treatment until the scheduling constraints are resolved or developing a plan for continued use of the skills during the break.

When CBCT for PTSD is delivered to nonromantic dyads, the therapy is conducted in largely the same manner as with romantic dyads, except for the session on physical closeness (Session 13). In this session, we focus the discussion of physical closeness on comfort in being in physical proximity to others (e.g., in public places), along with physical affection with family members and friends without inclusion of the role of sensuality or sexuality.

In CBCT for PTSD, we do not conduct individual sessions with partners except for individual sessions with each partner during the assessment process for the purposes of gathering a psychosocial history and assessing each partner's commitment to the relationship and physical safety (see below). We believe that meeting with one partner in the absence of the other once treatment commences undermines the conjoint frame. To this end, the treatment contract that a couple signs in the first session includes the provision that sessions will only occur when both partners are present.

One therapist typically delivers CBCT for PTSD. However, the use of cotherapists may be helpful, especially if one therapist is first learning the treatment, or if treatment is delivered in a multicouple group. On the occasions in which we have conducted cotherapy, we have also had "sidebar" conversations in which we consult with each other about the most helpful way to explain a skill or whether to stay on the topic at hand or move on to a new one while the couple "eavesdrops" or watches. In these instances, couples have reported finding it helpful to observe our decision-making process in real time and flexibility while interacting with one another.

The Role of the Therapist

When conducting CBCT for PTSD, the therapist takes an active role in collaboratively setting an agenda with the couple, and in pacing and guiding each therapy session to deliver the prescribed elements of each session. However, the therapist must bring to the therapy the essential but nonspecific elements of any efficacious treatment when following a manualized protocol. We take these elements very seriously in CBCT for PTSD, rating these elements (as well as the prescribed elements of the protocol's sessions) when rating clinicians for fidelity to the model.

Because of the structured nature of CBCT for PTSD, it is important to educate the couple at the outset that the therapy may be different from other forms of individual or couple therapy they may have received. As part of the informed consent process, the clinician should discuss what the couple can expect from the therapist (an agenda for each session, redirection when necessary to the topics at hand, coaching related to the skills or topic delivered in each session), as well as what is expected from the couple (e.g., attendance as a couple, completion of out-of-session assignments, and practice within each session). It is our experience that couples are quickly socialized to the more directive and experiential nature of the therapy if the therapist takes initiative at the outset to describe the expected course of therapy and follows the session content as prescribed.

As described earlier, each of the sessions after Session 1 is dedicated to in-session practice of the skills or productive discussion between the partners about the content introduced in that session. Partners are instructed to turn their chairs to face each other and to communicate directly with each other; the therapist serves as a coach for using the skills that have been taught in the therapy or guides discussion toward adaptive cognitions in the area of focus. In this way, CBCT for PTSD fosters experiential learning to increase the likelihood that the couple will use these skills outside sessions and will generalize them to other relationships.

Our model presumes that the couple is the unit of intervention, and the therapist needs to remain cognizant of joining the couple against PTSD and relationship problems versus pitting the partners against each other. The goal is to externalize the disorder so that it metaphorically exists within the partners' interactions and not within an identified patient. In CBCT for PTSD, the therapist facilitates communication between the partners, positioning them to speak directly to each other. The therapist should act as a coach to the partners in learning and using the skills to increase the likelihood of their using the skills outside sessions.

To stay goal-focused, we recommend that a therapist begin each session after Session 1 by inquiring about how the out-of-session assignment practice went, in contrast to asking general questions about how the partners are doing. General questions often lead to discussion about the most recent conflict or issues potentially tangential to the therapy and are difficult to redirect to the specific goals of the treatment. If the couple has issues that do not seem trauma- or PTSD-relevant, we encourage the therapist to save time at the end of the session to discuss these issues to reinforce doing the work of the session, yet meeting the specific needs of the couple. The skills taught in the protocol should be used to discuss these issues to reinforce skills acquisition.

For couples whose members are particularly distressed or emotionally volatile, it is important for clinicians to redirect them and create an experience within the therapy room that is different from their typical ways of interacting outside the therapy room. We discourage clinicians from reinforcing a negative mode of communication between partners by failing to intervene when there are negative emotional or behavioral exchanges. This is a major reason why the second session of CBCT for PTSD is focused on emotional and physical safety. The individual and conjoint conflict management skills are taught early on, so that the therapist can use these skills within any subsequent session as needed to achieve an optimal level of emotional and physiological arousal and to reinforce the skills being learned.

Assessment and Treatment Planning

We recommend a comprehensive assessment of both partners together and each person individually as part of providing high-quality care because multiple emotional and behavioral problems are likely to arise after traumatic stress exposure. Moreover, as mentioned earlier, partners of those with PTSD often have their own mental health symptoms. Toward this end, we recommend a three-session assessment process. If a couple initially presents for couple therapy, we recommend meeting with the partners together to hear their mutual rendition of couple-level problems, trauma-related symptoms, their expectations and hopes about therapy, and their respective motivations for engaging in therapy. To engender hope for the couple, it is important to inquire about any times in the relationship in which they experienced positive emotions and behaviors.

At the conclusion of the conjoint assessment session, the therapist is encouraged to schedule a second set of assessment sessions and meet with each partner individually for clinical and semistructured interviews. At these individual sessions, one partner can be interviewed while the other completes brief measures of mental health and relationship difficulties in a quiet office area. Then, the not-yet-interviewed partner meets with the therapist while the other completes the same measures.

With regard to the individual interviews, we recommend taking a psychosocial history and conducting relevant semistructured interviews. For PTSD, we recommend the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers, Blake, et al., 2013), a "gold standard" clinician interview that is available in the public domain and can be used to establish a PTSD diagnosis and a rating of PTSD symptom severity. The CAPS-5 may be administered to each partner if diagnoses of PTSD in both partners are suspected. For establishing other diagnoses, a careful clinical interview should be conducted, or relevant modules of a semistructured diagnostic interview can be administered.

In addition to these interviews, we recommend administering a self-report measure of PTSD symptoms such as the PTSD Checklist for DSM-5 (PCL-5; Weathers, Litz, et al., 2013), which is brief (it takes less than 5 minutes to complete), provides an overall severity score, and is subsequently administered at each treatment session to monitor therapy progress. We have created and routinely use a collateral version of the PCL-5 (PCL-5-Co; Monson, 2013) that asks significant others to rate their perception of their loved ones' PTSD symptoms on the measure. Partners' perception of patients' PTSD symptoms can provide invaluable clinical information in general, especially in light of research and our own clinical experience indicating that some individuals with PTSD may not fully appreciate, or may minimize or exaggerate, their posttraumatic stress symptomatology. Discrepancies found with this multimodal assessment can provide important clinical information regarding case conceptualization and possible barriers to maximal treatment benefit. Each partner should also complete an objective measure of relationship satisfaction. We use the Couples Satisfaction Index–32 (CSI-32; Funk & Rogge, 2007) at pretreatment because it has been shown to have excellent psychometric properties and is in the public domain. At each therapy session, we recommend administering the CSI-4 (Funk & Rogge, 2007), a brief version of the CSI-32 that also has excellent psychometric properties, to monitor progress in relationship satisfaction. In summary, the PCL-5 (self-report and collateral versions) and CSI-4 are administered at each session and tracked as objective measures of therapy progress. Other self-report measures of various comorbidities (e.g., depression, substance use) may be administered over the course of therapy to monitor progress in those areas as well.

In conducting the couple and individual assessments, it is important for the therapist to attend to sociocultural factors such as race, ethnicity, religion, gender identity, sexual identity, and age, all of which should be carefully considered during case conceptualization and in the delivery of CBCT for PTSD (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). Couples from minoritized groups may experience both unique sociocultural stressors and strengths that have relevance for recovery from PTSD and using the relationship as a vehicle for healing (e.g., Kelly, Jeremie-Brink, Chambers, & Smith-Bynum, 2020; McNeil Smith & Landor, 2018). For example, as a cultural group, Black couples and families are subjected to chronic stress in the form of racial discrimination and institutionalized forms of oppression (e.g., housing segregation resulting in Blacks being disproportionately likely to live in poor neighborhoods and exposed to community violence, health disparities due to unequal access to health care, and economic distress resulting from unequal access to education and employment). They can also experience collective grief through vicarious exposure to high-profile murders of Black individuals. At the same time, Black couples and families often also possess unique sociocultural strengths, such as a strong religious or spiritual orientation that helps them to prevail during difficult circumstances, the presence of extended family networks and "fictive kin" (i.e., individuals who are not related to the individual by blood but are considered family) who can provide social support and pool resources to navigate hardships, and egalitarian views about gender roles. A strong sense of racial identity and pride in belonging to this group is also an individual and collective resource. In our work with Black couples and couples from other minoritized groups, we have found it helpful to inquire about experiences of discrimination and related stressors, as well as sociocultural resources, during assessment and to name these factors explicitly when sharing the formulation with couples for the purposes of treatment planning. Doing so signals multicultural sensitivity and can facilitate treatment engagement.

Just prior to the first intervention session, we recommend that the therapist have the couple participate in a communication sample. This involves the partners' communicating for 5–10 minutes about a moderately distressing issue in their relationship while the therapist observes. This provides the therapist with clinically useful information about the couple's pretreatment communication, including strengths as well as areas in need of skills development. (See Monson & Fredman, 2012, for a complete description of how to set up the behavioral sample, what to observe, and how to provide feedback to the couple and segue to the first session's content.)

If an individual is referred or presents for PTSD treatment instead of couple therapy, we recommend that the therapist conduct the individual assessment session with the patient, and in the course of this session indicate a desire to speak with the client's partner because collateral report is a routine aspect of good clinical assessment. It is our experience that clients are generally willing to sign releases to speak with partners if the therapist provides this rationale and presents it as routine practice. Inclusion of partners in assessment can provide an excellent gateway into conjoint therapy, or, at a minimum, more information about PTSD and its comorbidities (e.g., substance use).

Goal Setting

Although the overall goals of CBCT for PTSD are to improve PTSD and enhance relational functioning, there is a specific focus on individualizing and operationalizing the accomplishment of these goals for a given couple. Individuals diagnosed with PTSD present with different constellations of the required symptom criteria for diagnosis. One patient may have significant dissociation that, if reduced, would represent improvements in the patient's PTSD, whereas another may have alterations in arousal and reactivity expressed in reckless/self-destructive or aggressive behavior. It is important for the therapist and couple to have a fine-grained understanding of how PTSD manifests in a particular individual and couple relationship to determine whether changes are occurring with therapy.

Likewise, some partners may have relatively little distress in their relationship, yet the structure and function of the couple's relationship are such that they maintain PTSD symptoms (e.g., accommodation). These factors need to be targeted in the therapy to maximize treatment efficacy and to help the partners learn different ways of expressing and receiving care and concern. Other distressed couples have distinct collections of areas in need of clinical focus, such as problems with physical intimacy, interpersonal aggression, hostility, or emotional disengagement. The therapist, with such a couple, identifies these particular areas of concern as the specific goals to be achieved with the course of therapy.

In Session 1, therapist and couple are tasked with identifying and writing down the couple's goals with regard to PTSD and the relationship, as well as operationalizing how the couple will know that these goals have been achieved. In other words, behaviorally specific and observable markers of goal attainment are identified. For example, a couple that identifies the patient's nightmares as a PTSD symptom to be improved would be asked by the therapist about the frequency and severity (i.e., periods of being awake or not after a nightmare) of current nightmares and to identify realistic goals for the future. In this vein, it is important that the therapist aim for reductions and not eradication of all symptoms to avoid the possible paradoxical effect of setting expectations too high. Similarly, a couple may identify more constructive arguments as a treatment goal. The therapist would inquire about how disagreements would look if there were improvements in this area. Depending on the level of functioning, one couple might identify not name-calling and leaving the house during arguments as improvements, whereas another, chronically avoidant couple might identify having disagreements that are discussed as evidence of improvements.

As noted earlier, we treat couples whose members report less severe physical aggression and in which each partner reports feeling physically safe in the relationship because many distressed couples endorse some act of physical violence in their relationship in the past year if asked (e.g., approximately 30%; Rowe, Doss, Hsueh, Libet, & Mitchell, 2011; see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich). With these couples, a mandatory goal of the therapy included in the goal-setting portion of Session 1 is the cessation of physical aggression. The therapist should specifically ask both members of the couple if they can contract for no physical violence during at least the course of the therapy, with the additional information that they will be learning conflict management strategies to diminish the likelihood of physical aggression. The therapist should also take a stand against any physical violence or symbolic aggression (e.g., throwing objects, punching walls) in the relationship, educating the couple that referrals for individual therapy will be necessary if physical violence is ongoing or escalates. Therapists are likewise instructed to take a stand against behaviors that are harbingers of violence (including name-calling, hostility, and other emotionally abusive behaviors) to increase emotional safety in the relationship. It is our experience that partners with less severe forms of physical aggression who each feel physically safe in the relationship have responded well to the therapy with these provisions in place.

Many couples we have treated have had a history of infidelity; we encourage clinicians to conceptualize infidelity as a relationship comorbidity that may be related to the presence of PTSD or may contribute to relationship distress. A couple in the throes of discovery of affair behavior is likely to need a period of stabilization before a course of CBCT for PTSD can begin (see also Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder). In the course of assessment, the therapist may determine that PTSD symptoms functionally contributed to the patient's participating in the affair as a way of avoiding intimacy with the partner or as a method of managing distressing emotions more generally. On the other hand, if the partner without PTSD has engaged in an affair, it will be important to consider and address how this has amplified the patient's PTSD symptoms in light of difficulties with trust that already existed, or how difficulties with intimacy contributed to the affair behavior.

Process and Technical Aspects of CBCT for PTSD

In keeping with our protocol, a "good termination" in CBCT for PTSD is characterized by declines in PTSD symptom severity and improvements in relationship functioning (e.g., increases in relationship satisfaction), which are monitored throughout therapy with self-report measures over the 15-session therapy. A successful couple will also be able to reflect on gains made over the course of treatment in behaviorally specific terms and to identify ways that they can continue shrinking the role of PTSD in their relationship over time. For example, a sexual assault survivor and her partner may identify that, compared with the start of treatment, the survivor is able to go out at night and ride public transportation to work. The couple no longer engages in name-calling during disagreements; the partners engage in sensual physical touch; and they socialize with friends at least two or three times per month. The partners decide that, going forward, they would like to travel by plane to a different state, where they will spend a week's vacation visiting extended family members, going to a theme park, and sightseeing.

Even for couples whose gains are more modest but whose members have exerted significant efforts in treatment, it is important to reinforce partners' commitment to each other and to treatment and discuss with them ways they can continue to experience improvements in PTSD and their relationship. We have also worked with couples who elect to terminate treatment prematurely (i.e., sooner than the full 15-session protocol) for a variety of reasons, including one partner's unwillingness to decrease substance misuse or complete trauma-related approach exercises at this time, or either partner's inability to engage fully in the work of therapy as a result of a health crisis in a family member or work demands that result in an erratic and unpredictable schedule. Under these circumstances, we believe that as long as the couple has made an informed decision based on a thoughtful understanding of the pros and cons of suspending treatment, this may still be considered a "good" termination. In these instances, we attempt to schedule a final session in which gains made thus far are discussed and future goals are identified to help provide a sense of closure to the work and to assist the couple in remaining receptive to additional treatment (whether individual or couple-based) in the future. Less ideal are circumstances in which a couple terminates treatment despite the therapist's best efforts to have at least one session to discuss gains made thus far and future goals. In these instances, we have found it helpful to follow up with several phone calls and a letter inviting the partners to return to treatment, even if only for a termination session to help them bring closure to this piece of work.

Observing the arc of this protocol, the exemplar therapist will essentially "work themselves out of a job." In other words, the goal of the therapy is to coach a couple to use the skills to be able to tackle new problems that may arise in the future. Toward this end, we focus on lapse prevention skills toward the end of therapy, to inoculate the partners against the inevitable problems that even happy couples have, and to prepare them for the possibility that something may occur that leads to a brief exacerbation of relationship problems or trauma-related symptoms (e.g., new trauma, relational stressors, trauma anniversary dates, salient trauma reminders).

Therapists can have their own emotional reactions when delivering CBCT for PTSD given the salience of PTSD-related hyperarousal, anger, sarcasm, and other negative behaviors that are sometimes directed toward therapists. When this happens, we try to model curiosity and a nonjudgmental attitude toward clients—and, whenever possible, to use this as a teaching opportunity by prompting clients to notice their thoughts, feelings, and behaviors in response to us and helping them to apply their skills. For example, one of us (SJF) made the assignment to a couple to notice pleasing and caring behaviors in each other, and the husband responded, "Gee, that sounds like a swell idea," while rolling his eyes. In response, the therapist said, "Peter, I experienced that as sarcasm. I'm wondering what thoughts and feelings you were experiencing just before you said that?" This helped the patient identify his underlying thought that the therapist did not think he and his wife were very intelligent and was intending to insult them by assigning this seemingly simple exercise. The therapist's ability to clarify that this is a simple yet powerful exercise that we ask all couples to do helped to correct this misinterpretation, without escalating a disagreement with the patient while he was activated. It also modeled for both partners how to maintain a curious stance even in the context of negativity. In addition, the therapist asked the couple whether this type of behavior occurred at home in response to perceived wrongdoing; she was able to highlight for the couple how this was an example of the way that PTSD can play out in a relationship and to describe how it could be modified by working together.

Some traumas may also be particularly difficult for a given therapist to hear. It is imperative that the therapist model being able to face versus avoid the realities of the traumatic experience for both the patient and the partner. As described earlier, we encourage adaptive disclosure in CBCT for PTSD by avoiding the fine-grained retelling of traumatic experiences, which is protective for not only partners but also therapists. That said, enough information must be shared and faced to enable a therapist to understand the context of the traumatic experience. Therapists experiencing distress related to a particular trauma or type of trauma should not feel ashamed or consider themselves weak or ineffective. Rather, they should seek consultation with trusted colleagues or experts in trauma treatment to understand and address their own reactions to be as effective as possible with couples. In some cases, a clinician may need to seek treatment for their own trauma history to be as healthy as possible to treat others with PTSD (see Norcross & VandenBos, 2018, for therapist self-care resources).

As a result of verbal aggression fueled by PTSD-related hyperarousal, therapists may at times feel anxious and intimated by patients and may experience a desire to avoid naming the aggression for fear that these patients will become even angrier or decide to drop out of treatment. Although this is an understandable reaction in response to feeling anxious, we strongly recommend that therapists model conflict management skills in the session despite their own anxiety; otherwise, by accommodating the patients' PTSD symptoms in this manner, they risk reinforcing the behavior and unwittingly recapitulating a maladaptive pattern of interaction that exists in couples outside the therapy session.

For example, one of us (SJF) treated a couple in which the PTSD-identified member threw his partner's cell phone through a window and broke a windowpane during an argument. The therapist inquired why the couple did not adhere to a predetermined safety plan, and the patient lashed out toward the therapist, saying, "I don't have to follow anybody else's rules! You're not listening to me, and you don't get to tell me what to do!" In this instance, the therapist felt quite anxious but calmly and firmly maintained control of the session by labeling this behavior as aggressive and calling a time-out: "Carl, I hear that you're angry right now. However, I'm experiencing your behavior toward me as aggressive, and we need to take a time-out right now so that we all feel safe and can have a productive conversation." Following a 10-minute break, the patient returned to the session and apologized to both the therapist and his partner; with the therapist's coaching, the partners were able to use their skills to discuss the role that PTSD had played in this interaction and how they could respond differently in the future. Had the patient (or couple) not respected the time-out or not been able to return to the session in a more calm and respectful manner, the therapist would have ended the session and developed a new safety plan for his wife. It is critically important that therapists also feel emotionally and physically safe when doing this work and model good conflict management skills. To manage these and other challenging clinical encounters, it is useful to participate in a consultation group in which members share how they have navigated similar events and help problem-solve and support.

One of the most common technical errors when practicing CBCT for PTSD is not following the treatment as prescribed. This can occur inadvertently, such as when the therapist has difficulty pacing session content and subsequently runs out of time to cover material that occurs toward the end of session. Common causes for this are spending too much time on out-of-session practice review (i.e., more than the recommended 30 minutes) or trying to achieve full resolution of a topic during in-session practice of a skill rather than using the in-session practice to illustrate the skill, then asking the couple to continue applying the skill to the topic at hand at home. We have found that with experience, most therapists get better at pacing sessions, and that fidelity improves in tandem.

More problematic, though, is a therapist's treating the protocol as a "menu," picking and choosing certain interventions (e.g., catching each other doing nice things, reflective listening) while omitting others (e.g., time-out technique, dyadic approach exercises). Many times, this occurs when therapists are reluctant to deliver protocol-based treatments, believing that such approaches are overly prescriptive or formulaic. For these same reasons, therapists may also neglect to assign out-of-session assignments or to follow up about them at the beginning of the next session. We advise against this, as each session and its key interventions were specifically designed to simultaneously address both PTSD symptoms and problematic relationship behaviors, particularly individual- and couple-level avoidance. To achieve maximum effectiveness in both domains (i.e., PTSD and relationship functioning), it is important that all skills are taught as prescribed within each session and that the couple practices the assigned skills out of session because the skills build on each other sequentially over the course of treatment and address PTSD-related avoidance. Failure to teach couples these prescribed skills as described in the manual runs the risk that either the PTSD or the relationship difficulties will not improve meaningfully by the end of the 15 sessions, which may inadvertently reinforce couples' beliefs that they are unable to get better. In contrast, adherence to the protocol as prescribed facilitates their ability to experience significant improvement in both PTSD and relationship functioning in a relatively brief period of time. Moreover, many couples report feeling pleasantly surprised that a structured treatment such as CBCT for PTSD was able to address the vast majority of their presenting concerns and allowed them to meet their couple-specific goals.

The other reason why we have found it helpful to conduct the treatment as prescribed is that the evidence we have for the therapy is based on therapists' conducting the therapy in this manner. We mention this not because the only clinical truth is that which is gleaned from randomized controlled trials, but rather because the research evidence provides a useful basis to "sell" the therapy to skeptical patients or couples in which one member suffers from chronic PTSD. Often, patients and partners are dubious that PTSD can be treated in only a few months, or that they can learn to relate to each other differently after years (or even decades) of interacting in a particular way. The fact that we have empirical evidence of the therapy's success is a compelling feature for many patients and their partners in deciding whether to proceed.

Another strategic error that therapists can make while practicing CBCT for PTSD is colluding in avoidance. Avoidance can take many forms, such as failure to complete out-of-session assignments as prescribed; frequently canceling and rescheduling appointments, so that couples are attending sessions less than once per week or not attending sessions at all; unwillingness to decrease substance misuse; or refusal to discuss the trauma and its effects even at the level of "broad brushstrokes," due to one or both partners' anxiety. Helping couples articulate the role of avoidance in the maintenance of PTSD and relationship difficulties often increases compliance with treatment, and couples begin to see improvements in both domains relatively quickly. However, if a couple continues to engage in high levels of avoidance that impede full participation in treatment beyond Session 4, we advise against proceeding with treatment. Otherwise, the couple is deprived of the opportunity to receive an adequate "dose" of treatment, and the partners run the risk that they will get to the end of the protocol and conclude that they cannot get better individually or as a couple.

A couple in which the patient is unwilling to share details of the traumatic event(s) with the partner even at the "big picture" level, or the partner is unwilling to hear trauma-related details, may still profit from participating in the first seven sessions of CBCT for PTSD, then using the newly learned skills to address cognitions related to present-day concerns that appear to maintain PTSD or relationship problems. Nonetheless, it is important for the couple to be able to discuss each partner's perception of the patient's symptoms and to engage fully in approach exercises and other out-of-session assignments designed to combat PTSD-related avoidance, emotional numbing, and unhelpful ways of thinking. Alternatively, the patient may be referred to individually delivered trauma-focused therapy, with the understanding that this may improve individual PTSD and comorbid symptoms but may not necessarily improve intimate relationship satisfaction or address maladaptive couple interactional patterns focal to PTSD (e.g., partner accommodation of PTSD symptoms).

MECHANISMS OF CHANGE

CBCT for PTSD aims to address interacting cognitive, behavioral, emotional, and relational factors that have been found to impede natural recovery after traumatization and to maintain

PTSD symptoms and relationship problems. As described earlier, the therapy initially utilizes behavioral interventions designed to improve conflict management and regulation of individual emotions. Behavioral communication skills are also taught and practiced to improve the emotional tone within the couple, to join the partners against PTSD, and to facilitate the later dyadic cognitive interventions involving some trauma disclosure in the dyadic context. Emotion identification and communication skills for sharing emotions are specifically taught and practiced to increase intimacy between the partners, to overcome the emotional avoidance that can maintain PTSD, and to decrease emotional numbing. Graded and dyadic-level behavioral approach assignments are also used to combat partner accommodation and the avoidance that maintains PTSD and diminishes the couple's shared relationship activities. These assignments facilitate new learning for the couple.

As discussed earlier, maladaptive appraisals of the traumatic event(s) held by either or both partners constitute a primary barrier to trauma recovery. These thoughts are specifically targeted with the dyadic cognitive intervention described earlier to facilitate trauma processing and improve relational functioning.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

To determine whether a course of CBCT for PTSD is appropriate for a given couple, we recommend implementing the relatively liberal inclusion–exclusion criteria we have used in clinical trials. The intervention has been tested with a range of traumatized individuals who vary with respect to type of index event, relationship satisfaction, and sexual orientation. Individual conditions or problems in either member of the dyad that we use as criteria for exclusion from the treatment include (1) substance dependence requiring a medical detoxification to safely decrease substance use; (2) *uncontrolled* severe mental health symptoms (i.e., active psychosis or mania; we have included those with these diagnoses if their symptoms were under relative control); (3) *severe* cognitive disorders; and (4) *imminent* suicidality and homicidality. We have emphasized particular words here because we have treated individuals with substance abuse diagnoses, major mental health diagnoses that are stabilized, a history of traumatic brain injury and mild cognitive impairments, and active suicidality without intention of self-harm.

The use of concurrent psychotropic medication is not contraindicated in CBCT for PTSD, with the exception of "as-needed" use of anxiolytics (e.g., benzodiazepines) because this can interfere with new learning during approach exercises and reinforce the patient's and/or partner's belief that the patient is unable to tolerate anxiety in a particular situation without the use of a pill. If patients have been on a stable dose of medication (which we operationally define as ≥ 8 weeks of the regimen) and are willing to remain on the same dose for the duration of treatment, the chances are good that they and their partners will attribute the gains they make to their hard work in the therapy rather than to the medication. They are also more likely to view the improvements made during treatment as durable, especially if the partners maintain their skill use.

With regard to possible relationship-oriented exclusions, we exclude couples in which one or both partners cannot express at least *minimal* commitment to the relationship, operationally defined as a willingness to commit to the 15 sessions of therapy. We also exclude couples in which there is ongoing infidelity in a relationship presumed to be monogamous, or *severe* relationship aggression (operationally defined consistent with the revised Conflict Tactics Scales [CTS2]; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) in the past year. Examples of severe relationship aggression include choking, kicking, punching, and slamming against a wall, and using physical force to coerce sexual activity. Physical aggression that results in injuries requiring medical care would also warrant exclusion. In cases of recent severe intimate partner aggression, individual or group therapy focused specifically on this aggression may be recommended. Following a period of time without physical aggression, couple therapy may then be initiated, with ongoing monitoring of aggression in the relationship.

If one or both members of the couple wish to terminate the relationship, they should be referred for couple therapy, with the goal of helping them achieve as amicable a dissolution of their relationship as possible, rather than CBCT for PTSD. If they can commit to the 15 sessions of the protocol, we encourage them to proceed with the therapy, adopting a "wait-and-see" attitude and putting their best feet forward, before determining whether they want to end their relationship (see also Chapter 21 on divorce, in this volume, by Lebow). Other couples for whom

CBCT for PTSD is not appropriate include those in the acute aftermath of the discovery of an affair, or those who identify distress related to one or both partners' infidelity as their primary presenting problem given that the primary focus of treatment in CBCT for PTSD is on the treatment of the identified patient's PTSD symptoms and the ways that the partners relate vis-à-vis the PTSD symptoms.

As reviewed in Liebman, Whitfield, Sijercic, Ennis, and Monson (2020), there have been seven case studies, five uncontrolled trials, and three randomized controlled trials demonstrating the efficacy of the original and adapted versions of CBCT for PTSD. Together, the results of these studies demonstrate that receiving CBCT for PTSD results in significant and large reductions in individuals' PTSD symptoms—reductions that are on par with, or better than, those obtained with existing individual evidence-based PTSD treatments. In addition, improvements across PTSD symptom clusters and co-occurring conditions have been found.

CBCT for PTSD has also been shown to lead to improvements in intimate relationship functioning and significant improvements in intimate partners' mental health. Research also suggests that CBCT for PTSD improves parenting satisfaction and efficacy among those with children. With regard to potential moderators of treatment outcomes, individuals with PTSD profit from the treatment across a broad range of initial levels of intimate relationship functioning, but especially those with higher levels of partner accommodation and those with higher levels of initial partner social support.

CASE ILLUSTRATION

Presenting Problem

Jennifer and Bob were referred for couple therapy by Jennifer's former therapist at an outpatient psychiatry clinic to address PTSD symptoms secondary to Jennifer's rape by a coworker in her early 20s and relationship difficulties. Jennifer and Bob were in their mid-40s, had been romantically involved for 17 years, and were married with three children. They reported that whenever they disagreed, Jennifer felt scared, which left Bob feeling confused and sad. She also made frequent excuses to avoid sexual intimacy, which left him feeling rejected and hurt. Jennifer reported feeling sad and uninterested in most things. According to the couple, they felt disconnected from each other, describing themselves more like "roommates" or "business partners" running a family than intimate partners. The partners reported that despite these difficulties, they were firmly committed to their marriage and their children and wanted to work as a team to address the role of PTSD in their relationship.

Assessment and Case Conceptualization

Jennifer had previously been treated with supportive individual therapy for PTSD related to childhood physical abuse by her mother. She also had a history of chronic major depression that had improved following a prior course of individual cognitive-behavioral therapy. She had no history of suicide attempts or self-harm behaviors and denied current active suicidal ideation. She endorsed passive suicidal ideation, indicating, "Sometimes I just think everyone would be better off without me." At the time Jennifer presented for treatment, she endorsed symptoms of PTSD in the moderate severity range, symptoms of major depression, and occasional panic attacks that did not meet criteria for panic disorder. She reported that her symptoms had worsened over the past year after a close friend disclosed that she had been sexually assaulted by a fellow service member while serving in the military. She denied a history of alcohol or other substance misuse. At the time of treatment, she was employed in the accounting department of a local grocery store chain and had worked in a human resources division at a federal government agency at the time of her rape. She had recently begun to take sick leave repeatedly after being assigned to a project that involved collaborating with a male colleague and was worried that she would lose her job if she did not begin attending work more regularly. Jennifer was prescribed an antidepressant by her primary care provider 6 months earlier but reported that it was modestly helpful.

Bob denied any current symptoms of psychopathology. He endorsed a history of major depressive disorder and alcohol use disorder after the couple's middle child, Jack, was severely injured by a car after running into the street before an adult could catch him. Jack had spent months in the hospital and was mostly physically recovered, with the exception of a slight limp in one leg. Bob had never received psychotropic medication and had never participated in psychotherapy, but he did attend Alcoholics Anonymous. He reported that his father and uncle currently suffered from alcohol use disorder.

After meeting with each partner and reviewing their self-report measures of PTSD severity, depression, anxiety, and relationship satisfaction, the therapist formulated the couple's case. She determined that Jennifer met diagnostic criteria for PTSD and major depressive disorder, recurrent, moderate. She also determined that Bob met criteria for past major depressive disorder (single episode, severe) and severe alcohol use disorder. Both Jennifer's and Bob's responses on the PCL placed her in the moderate range of symptoms for PTSD.

At a relationship level, each partner's responses on the CSI-32 indicated that Bob was in the low satisfied range and that Jennifer was in the mildly distressed range. On the CTS2, both denied any current or recent instances of physical or psychological aggression but did endorse a past history of severe physical aggression by Bob toward Jennifer. With further inquiry, the therapist learned that, in the wake of Jack's accident, Bob became severely depressed and coped with his distress by drinking to the point of blacking out. When he was drunk and the couple argued, he would occasionally lose control and punch Jennifer with a closed fist, resulting in bruises on several occasions. Jennifer subsequently moved into her sister's home and threatened to divorce Bob if he consumed alcohol again. At the time of their intake, Bob had abstained from alcohol for over 10 years, and Jennifer reported that she did not currently fear for her physical safety. The couple did not engage in name-calling or other forms of hostility but did report that their disagreements were often left unresolved. The therapist also determined that the couple was interacting in a way that was maintaining Jennifer's PTSD and comorbid symptoms. More specifically, Bob's collusion in her avoidance of work by calling in sick on her behalf and their avoidance of physical intimacy (i.e., his accommodation of her PTSD symptoms) were reinforcing a general behavioral strategy of avoiding rather than approaching uncomfortable situations. At the cognitive level, the couple's collusion in avoidance behaviors was also reinforcing Jennifer's belief that male coworkers were inherently dangerous and that she could not trust her own judgment to keep herself safe. Emotionally, it also deprived her of opportunities to learn to tolerate negative affect (e.g., anxiety, anger, sadness) without engaging in avoidant coping techniques (e.g., calling in sick to work, withdrawing from Bob if she anticipated conflict or physical intimacy).

During the pretreatment communication assessment, which focused on the topic of the couple's lack of physical closeness, the therapist observed that Jennifer seemed anxious and withdrawn, and Bob seemed sad and frustrated. Jennifer stated that she wanted to be emotionally and physically closer to him but felt overwhelmed with anxiety whenever they interacted in a way that she thought could lead to sexual intimacy (e.g., lying close to each other at bedtime). Bob responded that he was not just interested in sex and that he felt hurt that she tensed up and withdrew whenever he tried to be physically affectionate toward her. They did have strengths in their communication, including being respectful toward one another and refraining from hostility or interrupting each other. Bob also reached out and touched Jennifer's hand when she became tearful.

Phases 1 and 2 of CBCT for PTSD

The couple's first session focused on psychoeducation about PTSD and relationships, and on setting goals for treatment. The couple was educated about the cycle of PTSD symptoms, and Jennifer and Bob shared with the therapist how these symptoms manifested themselves within their relationship. Avoidance and emotional numbing behaviors, including Jennifer's frequent calling in sick to work and sense of detachment from Bob and the children, were specifically described as short-term efforts to decrease distress but ultimate impediments to new learning that needed to be addressed to facilitate recovery. The rationale for the therapy—specifically, for behavioral interventions to combat PTSD and improve the relationship (i.e., communication skills development and undermining numbing and avoidance) and for cognitive interventions to address their respective trauma-relevant cognitions—was presented.

Jennifer and Bob were especially encouraged to pick PTSD-relevant relationship goals (i.e., ways of relating as a couple that had been negatively affected by the presence of PTSD). Accordingly, both partners expressed a desire for increased physical intimacy (i.e., sexual intimacy, as well as physical affection that was nonsexual in nature); more direct communication (e.g., direct expression of opinions and wishes); and more family activities (e.g., playing games, watching movies, bike riding). Regarding PTSD, Jennifer identified as goals going to work regularly and trusting her own judgment in the form of expressing her opinions, even if they differed from those of others.

At the end of the session, Jennifer and Bob were asked to complete their first out-of-session assignment, which was to "catch each other doing something nice" (i.e., to monitor and reinforce positive relationship behaviors in each other) so as to build on the positives in their relationship. The partners were also asked to complete the Trauma Impact Questions (TIQs), a series of questions focused on each partner's beliefs about the impact of the trauma on them as individuals and as a couple; their beliefs about why the trauma occurred; and their current beliefs in the areas of trust, control, emotional closeness, and physical closeness.

The couple presented for Session 2 having completed their out-of-session assignments, and the therapist reinforced them for these efforts. Both partners indicated that although they had already been engaging in positive relationship behaviors, the assignment had allowed them to be more aware of the nice things they were doing for each other and had made this a more salient aspect of their relationship. They were then asked to read their responses to the TIQs to each other. The therapist noted Jennifer's response to the item addressing why the trauma occurred: "The rape happened because I encouraged his sexual interest in me." By contrast, Bob wrote, "This happened because Jennifer's coworker was a predator."

Following review of the practice assignments, the focus of Session 2 was on learning about their distress and anger, and on learning how to negotiate a time-out. The couple reported having few conflicts characterized by high emotional intensity on both of their parts and being relatively skilled at disengaging from highly negative interactions. However, they acknowledged that they often avoided conflict altogether or would never return to a conflictual topic to finish their discussion. The therapist explained that the time-out strategy could be used to counteract these tendencies by providing an opportunity to "time back in"; that is, the partners learned that after taking a time-out, they could return to the topic, continue their discussion, and make progress in understanding each other's views on the issue. The couple expressed understanding and willingness to attempt this new strategy and practiced it in the session.

Jennifer and Bob returned for Session 3 with good out-of-session assignment adherence and reported understanding the new skills. Phase 2 of treatment (Sessions 3–7) focused on improving the couple's communication skills and on helping them use communication as an antidote to behavioral avoidance and emotional numbing. During sessions, the therapist asked them to turn their chairs toward each other and practice their new communication skills on prescribed topics such as these: "As a couple, what kinds of things does PTSD make us avoid?" and "What would we do if we avoided less?" They were also taught to identify and differentiate thoughts and feelings.

To address couple-level avoidance, the couple, with the therapist's assistance, generated a list of feared places, people, things, and feelings. Jennifer and Bob then participated in *in vivo* approach activities that involved increasingly physically intimate behaviors that were not sexual per se, such as holding hands, hugging and kissing, and cuddling on the couch, with the instruction that Jennifer should tell Bob if she felt anxious during any of these activities and that Bob should reflect back her feelings. They also scheduled positive family activities one to two times per week.

To combat Bob's accommodation of Jennifer's PTSD symptoms, the couple agreed that Bob would not call in sick for Jennifer at work. Bob was also encouraged to express his opinions even if he worried that Jennifer might become anxious.

In Session 6, the couple was taught the U.N.S.T.U.C.K. process to challenge stuck points together. The couple proved quite adept at applying the U.N.S.T.U.C.K. process to Jennifer's thought "If I decline a request by a male supervisor or coworker, he'll hurt me." To reinforce Jennifer's newly emerging balanced thinking, she was subsequently assigned the approach task of telling her male colleague that she could work the early shift on Tuesdays but not Mondays as he had requested. To maintain the relational frame, the couple also applied the U.N.S.T.U.C.K. process to Bob's stuck points related to being a good partner by protecting Jennifer from distress, such as "If Jennifer wakes up in the morning and feels stressed about going to work, it's not okay for me to take care of myself by going to the gym." Doing what he needed to as part of his own self-care, despite Jennifer's emotional distress experienced in response to trauma-related cues, was identified as an approach task for Bob. This activity also served as a PTSD-related approach task for Jennifer to learn that she could tolerate her distress enough to go to work even if she felt apprehensive. In Phase 2, the partners were also taught problem-solving skills, which they used to solve issues such as addressing behavioral and experiential avoidance.

Phase 3 of CBCT for PTSD

By Session 8, Jennifer's PTSD and depressive symptoms had improved, according to objective and subjective assessment. The therapist helped the couple make the transition to the third phase of treatment by reviewing skills learned thus far and explaining that the focus of treatment would now shift to addressing historical appraisals of the trauma and unhelpful ways of thinking in the areas of trust, control, emotional closeness, and physical closeness. Using a handout from the protocol, the therapist then described common ways of thinking that can interfere with acceptance of the trauma and asked which of these might apply in the case of Jennifer's trauma. The couple decided that undoing (i.e., the tendency to play out the event or its antecedents with alternative courses of action that the person believes could have prevented it) was particularly relevant because Jennifer continued to blame herself for the event and to discount the role of the rapist, stating, "My behavior made me get raped." With the therapist's coaching, the couple applied the U.N.S.T.U.C.K. process to this stuck point. Below is an excerpt of the interaction that occurred in the therapy session.

THERAPIST: Jennifer and Bob, let's use the U.N.S.T.U.C.K. process to see if Jennifer might want to change her mind about some of the ways that she's been thinking about the trauma. You're going to approach this as a team (United) to explore the noticed thought that Jennifer's behavior caused the rape (Noticed thought). The next step is to see if there are alternatives to that thought (brainStorming). Bob, what questions do you have for Jennifer?

BOB: Jen, how could your behavior make someone rape you?

JENNIFER: I gave the impression that I wanted to have sex with him.

BOB: What do you mean that you "gave an impression of wanting to have sex" with him?

JENNIFER: I gave signals that I was interested in him.

BOB: What kind of signals?

JENNIFER: I flirted with him a few times, plus I used to wear short skirts.

BOB: So?

JENNIFER: So, that means I was giving off a sexual vibe.

BOB: What sexual vibe?

JENNIFER: It's like I was saying I wanted to have that kind of relationship with him.

BOB: But did you want a sexual relationship with him? Did you want any kind of relationship with him at all?

JENNIFER: No. (*Pauses.*) I told him multiple times that I didn't want to go out with him. I just liked that he thought I was attractive. Plus, I knew that I'd never date someone who was raised in [different country]. I know it's not a nice thing to say, but that's what I was thinking at the time given what my parents taught me.

BOB: So, if you never wanted any kind of relationship with him, sexual or otherwise, and declined his advances multiple times, how do you end up concluding that it's your fault that he ended up raping you?

THERAPIST: Great question, Bob.

JENNIFER: Because he felt sexually attracted to me. The fact that I kept talking to him after telling him that I didn't want to go out with him must have kept encouraging his sexual feelings for me. It's like I was saying, "Yes, I find you desirable," even though I was saying, "No, I don't like you in that way." See? It was unfair to do that to someone . . . make them find you sexually attractive but then not have sex with them. I made him think I wanted to.

BOB: Whoa.

JENNIFER: What?

BOB: All I can say is that a lot of women, and I mean *a lot*, turned me on, when I was young, but I never raped them.

JENNIFER: Huh.

BOB: Just because a woman might have flirted with me and I might have lusted after her doesn't give me the right to rape her.

THERAPIST: Jennifer, could you please reflect back to Bob what he just said regarding your thought that flirting with a man who you know finds you sexually attractive is somehow giving him permission to have sex with you?

JENNIFER: That I didn't owe him anything sexually. It was his responsibility to have acted on those feelings in a way that didn't involve raping someone.

THERAPIST: This seems like an important alternative thought to catch. Bob, can you please get down on the Big Picture sheet the thought "I didn't owe him anything sexually. He was responsible for acting on those feelings in a way that didn't involve raping someone." (*Bob writes this thought down on the Big Picture sheet.*)

THERAPIST: So, if it was his responsibility to deal with feelings of sexual arousal in a way that doesn't involve forcing unwanted sexual contact on someone else, whose fault was the rape?

Jennifer: His.

Therapist: In that case, what's the alternative thought? How can we boil that down to a sentence?

Jennifer: My rapist is to blame for the rape, not me.

Therapist: Bob, can you please get that down on the Big Picture sheet? (*Bob writes this thought down.*)

Therapist: I was also wondering about the night of the rape. When you met up with the rapist to finish the report, did you think this meeting would involve sex?

Jennifer: Definitely not. He said he was going to help me with a figure that I needed to make for a report.

Therapist: Do you think he thought it would involve a sexual encounter?

Jennifer: I don't know . . . I've never thought about it.

Therapist: Bob, what do you think?

Bob: Yes, definitely.

Therapist: What makes you so sure about that?

Bob: He had a knife on him.

Therapist: Can you tell Jennifer why you think that's so important?

Bob: Jen, he wasn't allowed to have any kind of weapon on him. It was a federal building. It's forbidden to bring a weapon onto federal property, and he would have known that. He went to that encounter with a concealed weapon.

Therapist: Jennifer, did you know that he had a weapon on him?

Jennifer: (*Shakes head no*). No way.

Therapist: Bob, can you ask Jennifer why he brought a concealed weapon with him to meet with her on federal property?

Bob: Jen, why do you think he had a knife on him when he met with you?

Jennifer: You're saying he must have known I wouldn't willingly have sex with him. He knew he'd have to force me.

Bob: Exactly. And, I have another question. What time of day did he ask you to meet him?

Jennifer: It was after work, maybe 6:00 or 6:30. No one else was around.

Bob: So, he wanted to get you alone there. No one would be there to help you when you screamed.

Therapist: Jennifer, a lot has been said here. Can you summarize what you're taking in?

Jennifer: The fact that he had a weapon on him and that he asked to meet me when no one else would be around means he premeditated me not consenting. (*Bob writes down these contextual details.*)

Bob: Jen, is there anything in this scenario that remotely seems like your behavior caused him to rape you?

Jennifer: No. (*Pauses.*) When I take a step back and think about everything going on beforehand and the fact that he had a knife and the time of day it was, it's like he planned the whole thing, knowing that I wouldn't go along with this willingly.

Therapist: Let's definitely get that down on paper. (*Bob writes that the rape was premeditated on the Big Picture sheet*).

Therapist: (*continuing*) Jennifer, you're doing a great job thinking about this from a Big Picture perspective to understand what happened and why and, Bob, you're doing a great job staying curious and asking questions. Let's now apply the next steps to Test out these alternative thoughts (T) and to Use the most balanced one (U).

Jennifer: Based on this discussion, it seems like it wasn't my behavior that made me get raped. He knew that I didn't want this and that he was going to have to use force to get his way.

Bob: Yes, the blame lies with him, not you.

Therapist: Yes, we could say that the situation was, in essence, determined to happen given that he planned this out and had the element of surprise on his side. What do you think of that?

Jennifer: It's hard to sit with the fact that I was helpless and that there's nothing else I could have done at the time. (*Becomes tearful, and Bob holds her hand.*)

Therapist: It is. And, as the same time, this also means that you're not to blame for the rape. He is.

Jennifer: Thinking about it that way does make me feel better.

Therapist: I'm very happy to hear that. We've talked about a bunch of alternative thoughts. Jennifer, which of these feel the most balanced to you? Which resonate with you the most?

Jennifer: When Bob told me that a lot of women aroused him but that he didn't rape them. That really made me see that sexual attraction does not give someone the right to do whatever they want to you.

THERAPIST: How do you feel (C, for Change in feelings and behaviors) when you go from the noticed thought that your behavior made you get raped to the alternative thought that he's to blame for his behavior, not you?

JENNIFER: Less ashamed and less sad. Also, less angry at myself and more angry at the rapist.

THERAPIST: And now for the last step, Keep practicing (K). How will the two of you keep this new thought going?

JENNIFER: To keep reading the sheet and to talk with Bob to remind me.

Over the remainder of Phase 3, Jennifer and Bob continued to use their skills with good effects to challenge other stuck points (e.g., "I have bad judgment about people's trustworthiness," "A desire for alone time means that she doesn't want to feel close to me"). By the conclusion of the 15 sessions of treatment, Jennifer no longer met diagnostic criteria for PTSD, her depression had remitted, and she was no longer feigning illness to avoid going to work. For his part, Bob reported feeling happier and less stressed. The couple also reported that their children seemed more contented and relaxed as their parents seemed more harmonious and joyful.

At the relationship level, both partners' relationship satisfaction increased, and Jennifer was no longer in the distressed range. They were engaging in some form of physical affection daily and engaged in sexual intercourse approximately once per week. They were also being more direct and open in their communication about relationship issues and were better able to resolve their differences. To maintain their gains, the partners decided to devote the time that they had been meeting with the therapist to continuing to practice their skills to help consolidate their gains.

The couple returned for a check-in session 3 months later. At that session, Jennifer's PTSD symptoms had decreased further. She reported that she was still successfully working at the grocery chain and was working toward a certificate that would make her eligible for a promotion within the company. The couple also reported that they had continued to engage in physical closeness in the form of both physical affection and sexual intimacy.

CONCLUDING COMMENTS

CBCT for PTSD is a disorder-specific couple therapy for PTSD designed to simultaneously treat PTSD and enhance intimate relationship functioning. In recognition of the inherently interpersonal context of the disorder, its consequences, and opportunities for recovery, it targets cognitive, behavioral, and affective processes within and between members of a couple that can contribute to and maintain PTSD symptoms and relationship impairments. Nearly 20 years of research on CBCT for PTSD demonstrate that CBCT for PTSD is associated with improvements in patients' PTSD symptoms, partners' psychological distress, and couples' relationship adjustment, indicating that a single intervention can promote gains in multiple outcomes and for multiple individuals within a couple or family system at the same time. It is our hope that ongoing research on the delivery of CBCT for PTSD and its mechanisms of action will spur further innovations in conjoint approaches to the treatment of PTSD to promote the health and well-being of trauma survivors and their loved ones.

SUGGESTIONS FOR FURTHER STUDY

Blount, T., Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., & Monson, C. M. (2015). Cognitive-behavioral conjoint therapy for PTSD: Application to an Operation Enduring Freedom (OEF) veterans. *Cognitive and Behavioral Practice, 22*, 458–467.

Liebman, R. E., Whitfield, K., Sijercic, I., Ennis, N., & Monson, C. M. (2020). Harnessing the healing power of relationships in trauma recovery: A review of cognitive-behavioral conjoint therapy for PTSD. *Current Treatment Options in Psychiatry, 7*, 203–220.

Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for PTSD: Harnessing the healing power of relationships*. New York: Guilford Press.

www.coupletherapyforptsd.com: "For Members" section includes web-streamed video of delivery of key interventions. Members-only access available with attendance at Foundational CBCT for PTSD Workshop attendance. See website for training dates.

REFERENCES

Allen, E., Renshaw, K., Fredman, S. J., Le, Y., Rhoades, G., Markman, H., & Litz, B. (2021). Associations between service members' PTSD symptoms and partner accommodation over time. *Journal of Traumatic Stress, 34,* 596–606.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 66,* 53–88.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68,* 748–766.

Campbell, S. B., & Renshaw, K. D. (2018). Daily posttraumatic stress disorder symptom accommodation and relationship functioning in military couples. *Family Process, 58,* 908–919.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 319–345.

Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., Wagner, A. C., Vorstenbosch, V., & Monson, C. M. (2016). Partner accommodation moderates treatment outcomes for couple therapy for PTSD. *Journal of Consulting and Clinical Psychology, 84,* 79–87.

Fredman, S. J., Vorstenbosch, V., Wagner, A. C., Macdonald, A., & Monson, C. M. (2014). Partner accommodation in posttraumatic stress disorder: Initial testing of the Significant Others' Response to Trauma Scale (SORTS). *Journal of Anxiety Disorders, 28,* 372–381.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21,* 572–583.

Glynn, S. M., Eth, S., Randolph, E. T., Foy, D. W., Urbaitis, M., Boxer, L., . . . Crothers, J. (1999). A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67,* 243–251.

Jacob, S. N., Dodge, C. P., & Vasterling, J. J. (2019). Posttraumatic stress disorder and neurocognition: A bidirectional relationship? *Clinical Psychology Review, 72,* Article 101747.

Kelly, S., Jeremie-Brink, G., Chambers, A. L., & Smith-Bynum, M. A. (2020). The Black Lives Matter movement: A call to action for couple and family therapists. *Family Processes, 59,* 1374–1388.

Lambert, J. E., Engh, R., Hasbun, A., & Holzer, J. (2012). Impact of posttraumatic stress disorder on the relationship quality and psychological distress of intimate partners: A meta-analytic review. *Journal of Family Psychology, 26,* 729–737.

Liebman, R. E., Whitfield, K., Sijercic, I., Ennis, N., & Monson, C. M. (2020). Harnessing the healing power of relationships in trauma recovery: A review of cognitive-behavioral conjoint therapy for PTSD. *Current Treatment Options in Psychiatry, 7,* 203–220.

McLean, C. P., & Foa, E. B. (2017). Emotions and emotion regulation in posttraumatic stress disorder. *Current Opinion in Psychology, 14,* 72–77.

McNeil Smith, S., & Landor, A. (2018). Toward a better understanding of African American families: Development of the sociocultural family stress model. *Journal of Family Theory and Review, 10,* 434–450.

Meyer, E. C., Morissette, S. B., Kimbrel, N. A., Kruse, M. I., & Gulliver, S. B. (2013). Acceptance and Action Questionnaire–II scores as a predictor of posttraumatic stress disorder symptoms among war veterans. *Psychological Trauma: Theory, Research, Practice, and Policy, 5,* 521– 528.

Monson, C. M. (2013). *PTSD Checklist for DSM5—Collateral Version (PCL5-Co).* Available from C. M. Monson at candice.monson@.ryerson.ca.

Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for PTSD: Harnessing the healing power of relationships.* New York: Guilford Press.

Monson, C. M., Fredman, S. J., Dekel, R., Ennis, N., & Macdonald, A. M. (in press). Family models of posttraumatic stress disorder. In J. G. Beck & D. M. Sloan (Eds.), *Oxford handbook of traumatic stress disorders* (2nd ed.). New York: Oxford University Press.

Mowrer, O. H. (1960). *Learning theory and behavior.* Hoboken, NJ: Wiley.

Norcross, J. C., & VandenBos, G. R. (2018). *Leaving it at the office* (2nd ed.). New York: Guilford Press.

Ozer, E. J., Best, S. R., Lipsey, T. L., Tami, L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129,* 52–73.

Pitman, R. K., Altman, B., Greenwald, E., Longpre, R. E., Macklin, M. L., Poiré, R. E., & Steketee, G. S. (1991). Psychiatric complications during flooding therapy for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 52,* 17–20.

Renshaw, K. D., Allen, E. S., Fredman, S. J., Giff, S. T., & Kern, C. (2020). Partners' motivations for accommodating posttraumatic stress disorder symptoms in service members: The Reasons for Accommodation of PTSD Scale. *Journal of Anxiety Disorders, 71,* Article 102119.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70,* 867–879.

Reuman, L., & Thompson-Hollands, J. (2020). Family accommodation in PTSD: Proposed considerations and distinctions from the established transdiagnostic literature. *Clinical Psychology: Science and Practice.* [Epub ahead of print]

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5,* 455–475.

Rowe, L. S., Doss, B. D., Hsueh, A., Libet, J., & Mitchell, A. E. (2011). Coexisting difficulties and couple therapy outcomes: Psychopathology and intimate partner violence. *Journal of Family Psychology, 25,* 455–458.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 7,* 283–316.

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: A meta-analysis. *Journal of Consulting and Clinical Psychology, 79,* 22–33.

Tarrier, N., Sommerfield, C., & Pilgrim, H. (1999). Relatives' expressed emotion (EE) and PTSD treatment outcome. *Psychological Medicine, 29,* 801–811.

Wagner, A. C., Monson, C. M., & Hart, T. L. (2016). Understanding social factors in the context of trauma: Implications for measurement and intervention. *Journal of Aggression, Maltreatment & Trauma, 25,* 831–853.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5).* Available from the National Center for PTSD at *www.ptsd.va.gov.*

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5).* Available from the National Center for PTSD at *www.ptsd.va.gov.*

CHAPTER 25

Couple Therapy for Alcohol Problems

Barbara S. McCrady, Elizabeth E. Epstein,
and Cathryn Glanton Holzhauer

BACKGROUND

That alcohol and couple problems are interwoven is a fact well known to mental health professionals and addiction specialists. Less well understood are the factors that maintain relationships in which problematic alcohol use is involved and how positive change can be effected both for persons with a drinking problem and for their relationships. Scientific efforts to understand the associations between drinking and marriage have been reported since the early 1900s, and treatment models that address both drinking and couple functioning have been developed and tested for more than 75 years. In this chapter, we present alcohol behavioral couple therapy (ABCT; McCrady & Epstein, 2009a, 2009b)—our research-based model for conceptualizing and treating individuals with alcohol problems and their partners—and address clinical techniques and issues in the implementation of ABCT.

Drinking and the couple relationship are often so closely bound that clinicians have referred to the "alcoholic marriage"[1] (reviewed in Paolino & McCrady, 1977). Early theoretical models suggested that women married men with an alcohol use disorder (AUD) as a defense against neurotic conflicts with control or dependency. These models suggested that these wives needed their partners to continue to drink to avoid more serious decompensation themselves. These early psychodynamic models firmly placed responsibility for an individual's continued drinking in the hands of the "disturbed" spouse. These models have not been supported by research. Sociological perspectives, predominant in the 1950s and 1960s, viewed the spouse as responding to the chronic stress introduced by living with a partner with an AUD, placing responsibility for the family's problems with the drinking partner rather than the other partner. Family systems models, which first came to prominence in the 1970s and 1980s, emphasized the homeostatic balance between drinking and family functioning, hypothesizing that drinking stabilized the family system and allowed for the expression of certain facets of family relationships that could not be expressed during sober periods (e.g., Steinglass, Bennett, Wolin, & Reiss, 1987).

Contemporary models of AUD and couple relationships are based on social learning theory and family systems models, and draw from empirical literatures on interactional behavior, the connections between individual psychopathology and interactional behavior, and the broader literature on social support. ABCT includes elements of motivational enhancement to change drinking and interactional behavior; behavioral skills interventions to facilitate changes in drinking; skills training to help the significant other (SO) cope more effectively with drinking-related situations and support abstinence; and reciprocity enhancement and communication techniques drawn from behavioral couple therapy to improve relationship functioning. ABCT treatments developed by different investigators vary in their degree of emphasis on these domains (McCrady & Epstein, 2009a [ABCT]; O'Farrell & Fals-Stewart, 2006 [called BCT]). ABCT and BCT differ in that ABCT includes assistance to help the identified patient (IP) change their drinking, as well as coping skills for the SO and relationship changes; BCT is designed to complement separate treatment focused on helping the IP change their drinking. The ABCT and BCT models have been adapted to treat other substance use disorders (SUDs; Epstein et al., 2007; O'Farrell, Schumm, Murphy, & Muchowski, 2017) but, in general, the body of research on ABCT and BCT for other SUDs is limited.[2] Thus, this chapter focuses primarily on alcohol problems and presents the ABCT model of treatment.

---

[1] To avoid the stigmatizing language of "alcoholic," we use the term "AUD couples" to refer to couples in which one or both partners have an alcohol problem.

CORE UNDERSTANDINGS ABOUT ALCOHOL PROBLEMS IN COUPLE THERAPY

Definitions, Diagnosis, and Prevalence of Alcohol Problems

Substance-related disorders, as specified in the text revision of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), are defined on a continuum of severity ranging from mild to severe; the term "substance" refers to alcohol or any of nine other classes of drugs. Diagnosis of an AUD or other SUD requires the presence of at least two of 11 criteria related to drinking patterns, impairment, and physiological effects that have occurred within a 12-month time frame and caused clinically significant impairment or distress. AUD has a prevalence of about 8.0% in adult males and 7.7% in adult females; about 25.8% of adults report binge drinking (five or more drinks for males; four or more drinks for females) in the past month (National Institute on Alcohol Abuse and Alcoholism, 2020).

Behavioral researchers and clinicians generally are less concerned about AUD diagnosis and more concerned about understanding the problems caused by an individual's alcohol consumption. Alcohol consumption occurs on a continuum from light or infrequent to heavy and frequent drinking, but negative consequences may occur at almost any level of use, depending on the contexts of the drinking, an individual's health status, familial or occupational situation, and cultural or religious traditions. Therefore, it is important to understand what makes an individual's drinking problematic within their relationship regardless of diagnosis.

Couple Distress and Alcohol Problems

Extensive research has demonstrated a reciprocal relationship between drinking and relationship functioning in which alcohol use affects the quality and nature of a relationship and the relationship affects the alcohol use. Longitudinal studies of engaged couples have found that husbands' premarital drinking is a strong predictor of their wives' drinking a year into marriage; that couples who have similar heavy or light drinking patterns have happier and more stable marriages than those with dissimilar drinking patterns; and that relationship distress and AUD are strongly related (Muyingo et al., 2020).

Sexual dysfunction and dissatisfaction also are common in AUD couples. In general, their sexual problems are like those of couples with other types of conflict, but erectile dysfunction is a more common problem in males who are heavy drinkers or have an AUD (Allen & Walter, 2018). A recent meta-analysis found no relationship between women's drinking and sexual dysfunction (Allen & Walter, 2018). Married women with alcohol dependence have reported drinking in order to function in their relationships, to be more assertive, and to deal with sexual "demands" from partners (Lammers, Schippers, & van der Staak, 1995).

Results from clinical and nonclinical samples reveal a close association between heavy drinking and intimate partner violence (IPV; Caffereky, Mendez, Anderson, & Stith, 2016). AUD couples have high rates of IPV, regardless of the sex of the partner with the AUD (Drapkin, McCrady, Swingle, Epstein, & Cook, 2005) and drinking is common during episodes of interpersonal violence (Caetano, Schafer, & Cunradi, 2001).

AUD also affects family members. The partners and children of men with AUD experience psychological distress, health problems, and behavioral problems. Wives of actively drinking men have elevated levels of depression, anxiety, and psychosomatic complaints, and utilize more medical resources; children growing up with a parent with an AUD experience a variety of psychological, behavioral, and school problems. There is less research on the impact on male partners of women with AUD (McCrady & Flanagan, 2021).

---

[2] Serious concerns have been raised about the veracity of the body of research conducted by Dr. Fals-Stewart (see *www.ag.ny.gov/press-release/new-york-state-attorney-general-andrew-m-cuomo-announces-charges-against-former-ub*); therefore, his research related to BCT for males with SUDs and BCT for females with AUDs is not included in this chapter.

Conceptual Model of Alcohol Problems and Couple Functioning

The ABCT model integrates research findings about alcohol and couple relationships, and draws from sociological, family systems, and behavioral perspectives. We understand many behaviors of the SO as attempts to cope with a difficult situation, but the reciprocal interactions between the partners are key to understanding repetitive and dysfunctional interaction patterns. We assume that drinking can be treated best by focusing primarily on current factors maintaining the drinking. Factors maintaining drinking may be nondyadic and/or dyadic (i.e., rooted in the interpersonal relationship). The model assumes that (1) external antecedents to drinking have a lawful relation to drinking through repeated pairings with positive or negative reinforcement or through the anticipation of reinforcement; (2) internal physiological, cognitive, and affective states mediate the association between external antecedents and drinking behavior; (3) expectancies about the reinforcing value of alcohol play an important role in drinking behavior; (4) drinking is maintained by its more immediate physiological, psychological, or interpersonal positive consequences; and (5) negative consequences of drinking tend to be delayed and therefore have less impact on an individual's ability to resist drinking in the face of craving.

A variety of individual, familial, and other interpersonal factors may be associated with drinking. (See McCrady & Epstein, 2021, for a fuller description of individual and nonfamilial interpersonal factors.) In addition, antecedents to drinking may occur at the familial level. Alcohol use may be part of family celebrations or daily rituals. Family members may attempt to influence the IP's drinking, using tactics such as nagging or attempting to control the drinking through control of the finances or the liquor supply. Families in which alcohol problems are present often have evolved poor patterns of communication and problem solving, and have developed relationship, sexual, financial, and childrearing problems over time. These behaviors and stressors can serve as antecedents to further drinking, which in turn worsen the stressors. The drinking individual may have a range of reactions to these familial antecedents, experiencing negative affect, low self-efficacy for coping with problems, or retaliatory thoughts (e.g., "She's not going to control me").

Some positive consequences of drinking may unintentionally come from the family. For example, families often engage in caretaking of the drinking member (e.g., Rotunda, West, & O'Farrell, 2004) by, for example, cleaning up after them, covering at work, or being particularly gentle and nonconfrontational during drinking episodes. These behaviors can be understood as normal reactions when a family member is ill, but when applied in the context of AUD families may end up reinforcing drinking.

Families also create negative consequences for drinking such as withdrawal of attention and avoidance of the drinking member; negative verbal comments about the drinking (either during or after a drinking episode); or physical violence directed at the drinking member. These negative consequences, instead of suppressing the drinking, may have undesired effects. For example, the IP may begin to avoid the family when drinking or try to hide the drinking. Hiding, in turn, may lead to couple interactions characterized by mistrust around the drinking individual's avoidance and lying, and to hypervigilance by the nondrinking partner. In addition, negative consequences from family members may be cues for further drinking, creating a circular pattern of negative interactions between the drinker and the rest of the family.

In summary, the ABCT model posits that the drinking behavior of a person with an AUD is embedded in a complex network of factors relating to the individual's physiology and psychology, the family, and other social networks. There is a reciprocal relation between the drinking and the functioning of network; the individual's behavior both influences the social network and is influenced by it.

Cultural and Other Nondyadic Factors and AUDs

Several important nondyadic factors contribute to the etiology and maintenance of alcohol problems. First, there is fairly strong evidence for the familial transmission of more severe forms of drinking problems. Persons with a parent with an AUD are at increased risk for developing an

AUD themselves (particularly males who have a male parent with an AUD). Family-of-origin interactions of both the drinking individual and the partner also contribute to the etiology and maintenance of alcohol problems (see McGue & Irons, 2013).

A second important individual factor is the high comorbidity of AUD with other psychiatric disorders. The most common comorbid disorders, aside from other SUDs, are depression and anxiety disorders. The most common personality disorders found to be comorbid with AUD are antisocial and borderline personality disorders (Rosenthal, 2013).

Third, individual differences in gender, race/ethnicity, and age have implications for couple treatment of AUD (Castro, Garvey, Kellison, & Marsiglia, 2013; Satre, 2013). Some research in women with AUD suggests that their partners are more likely also to have alcohol or drug problems, that women are more likely to drink in response to relationship discord, and that their male partners are less involved and responsive to the women's drinking (Green, Pugh, McCrady, & Epstein, 2008). Unfortunately, there is a paucity of research on AUD couple interactions in racial and ethnic/minority couples or in sexual and gender minorities (McCrady & Flanagan, 2021).

In summary, treatment for persons with alcohol problems occurs within a complex network of psychological, sociocultural, familial, and interpersonal contexts and problems. The ABCT model takes this complexity into account.

THE PRACTICE OF COUPLE THERAPY FOR ALCOHOL PROBLEMS

The Structure of the Therapy Process

Therapy is conducted in weekly conjoint sessions, typically 90 minutes in length, with one therapist working with a couple. For our research studies, we have seen couples for 12–20 weekly sessions over 3–6 months, but this arrangement can be tailored to individual situations in the clinical setting. Each session begins with the use of a hand-held Breathalyzer or alcohol saliva strip to assess whether or not the IP has any alcohol in their system. The therapy session typically proceeds with a general check-in, followed by a review of self-monitoring cards (described below) and a discussion of other homework. The balance of the session revolves around specific topics introduced by the therapist, as well as work on therapeutic issues introduced by the couple. Even when session content is focused on individual behavior change (e.g., self-management skills to avoid drinking situations), both partners are actively engaged in the treatment; the therapist encourages the couple to interact, providing guidance and coaching on specific communication skills during these interactions. Treatment is active and goal-directed, and sessions include problem solving and behavioral rehearsal of new skills. Time is allotted at the end of each session to review high-risk situations for drinking during the subsequent week. We use a worksheet for this, writing down the situations, as well as a plan to deal with each one without drinking. Homework for the week is assigned and written down at the end of the session. Treatment is guided by a therapist manual (McCrady & Epstein, 2009a), and a client workbook is available (McCrady & Epstein, 2009b).

Both partners attend every session to educate about both the nature of drinking problems and the model of change; to decrease the avoidance, lying, and hypervigilance that may characterize the relationship; to improve communication and problem-solving skills; and to use the differing perspectives of each partner to increase the information available to the therapist. Under certain circumstances, separate individual sessions are an appropriate part of an overall conjoint treatment approach. IPV is always assessed individually, and individual sessions are also considered if there are continued concerns about IPV, when one or both partners are involved in extramarital affairs, or when the volatility or hostility in the couple's relationship interferes with therapy. In general, partners are told that individual communications with the therapist may be brought up in the conjoint session at the therapist's discretion unless there is a concern that a disclosure could result in harm to one of the partners. IPs may be referred to a physician or detoxification program for medication to assist with alcohol withdrawal at the beginning of treatment and may be referred for medication to help maintain abstinence from alcohol or to help manage a co-occurring psychiatric disorder.

Therapy typically follows a sequence in which stopping or reducing alcohol consumption is the primary focus of early treatment sessions; the relationship increasingly becomes a target for attention as therapy progresses. As the IP is successful in changing the drinking, the SO frequently becomes more amenable to examining and changing their behavior. Discussing alcohol-related topics that affect the couple as a unit, encouraging simple shared activities, and teaching the partner to provide reinforcement for positive changes in drinking are the earliest interventions directed at the couple as a unit, and provide a medium for the introduction of communication and problem-solving skills. As treatment progresses, the therapist focuses more on the couple relationship. Table 25.1 provides a complete list of interventions.

The Role of the Therapist

The ABCT therapist is an expert consultant, with knowledge about alcohol, alcohol problems, and ways to change drinking and resolve couple problems. Taking the stance of a collaborator/coach, teacher, and consultant helps in the development of a therapeutic alliance with the couple against the alcohol. The therapist refrains from judging either partner's position and explains that both partners will learn new skills in therapy. The therapist's neutral, collaborative, teaching approach is intended to decrease both partners' concerns that they are being judged and motivate them to accept and practice the new skills.

Establishing and Fostering a Working Alliance

The therapist's relationship to the couple and the therapeutic stance assumed by the therapist are important. Empathy, active listening, motiva-

TABLE 25.1. Outline of Session-Specific Treatment Techniques (12-Session Therapy)

Session	Individual intervention	Partner intervention	Couple intervention
1	Feedback and motivation enhancement Abstinence plan Self-recording	Motivation enhancement Partner support for change Self-recording	
2	Functional analysis		"Notice something nice"
3	High-risk hierarchy Self-management planning	Functional analysis	Continue "notice something nice"
4	Continue self-management planning Decisional matrix	Functional analysis	"Notice something nice" and feedback Discussion of alcohol in the house
5	Dealing with urges Review of skills and progress	Partner role in dealing with urges Decreasing partner triggers	
6	Rearranging behavioral consequences	Partner decreasing protection	Shared activity
7	Dealing with alcohol-related thoughts		Shared activity plan Introduction to communication
8	Drink refusal training		Extending shared activity Communication skills
9	Seemingly irrelevant decisions	Partner role in drink refusal and drinking situations	Communication: Leveling and editing
10	Relapse prevention: Relapse warning signs		Communication: Problem solving
11	Handling slips and relapses	Partner role in handling slips and relapses	Acceptance/change framework
12	Review and planning for maintenance	Review and planning for maintenance	Review and planning for maintenance

tional reframing, instillation of hope, and establishing a sense that the therapist and both clients are working toward mutually agreed-upon goals are essential (McCrady & Epstein, 2021). However, in couple therapy with individuals with AUD and their partners, such a stance is sometimes difficult. By treating an IP who may be ambivalent about stopping drinking, along with an SO who wants the IP to stop or decrease drinking, the therapist is allied de facto with the SO. Because of the inherent imbalance in the treatment relationship, the therapist must make particular efforts to align with the IP. Developing such an alliance may be difficult because the therapist may find some of the IP's behavior during treatment frustrating, and because of the history of drinking-related behaviors that the therapist and SO may find upsetting. To further complicate the therapist's task, comments supporting the IP may anger or frustrate the SO, who may have been experiencing anger at the IP's alcohol use for quite some time.

The therapist uses several techniques to handle the difficulties of the inherently imbalanced nature of the therapy. First, the therapist must be mindful to separate the IP as a *person* from the IP's *behaviors* in regard to alcohol, and to connect with the IP's positive characteristics and strengths. Second, the therapist needs to validate the perceptions and information of each partner. Empathizing with how difficult the IP finds honesty about drinking after having tried to hide their drinking from everyone while also empathizing with the SO's frustration with the IP communicates that the therapist is concerned about and respects both partners' experiences. Third, the therapist must align with the goals of the therapy—to makes changes in the IP's drinking, decrease problems caused by the drinking, and improve the couple's relationship.

In addition to managing the potentially imbalanced therapeutic relationship, the therapist may use other techniques to foster a working alliance with the couple. For example, the therapist may predict for the couple that new and perhaps upsetting information will emerge during the sessions; this prediction normalizes these discoveries as a positive part of the change process. The therapist also forms an alliance by making expectations clear, for the therapist and for both partners (e.g., attending sessions reliably and on time, attending sessions sober, providing evidence-based treatment). Finally, it is important to provide copious and genuine encouragement to the couple. Changing a habitual drinking pattern is difficult; there may be slips or relapses during treatment; and it is sometimes difficult for the couple and the therapist to remain optimistic about the outcome of treatment. Therapy sessions also may be painful for both partners. The therapist needs to be aware of this and to highlight the "bigger picture" to help both the IP and SO be willing to tolerate the discomfort of therapy and to feel more optimistic by the end of each session. The slow, difficult process of changing drinking involves learning to deal with cravings, rearranging one's lifestyle and daily habits, developing and sustaining a sober relationship, and facing painful issues without the help of alcohol. For the SO, learning to respond differently to the IP and developing trust in the IP's changes are necessary tasks. For the couple, reestablishing communication, learning to support each other, being able to move forward in their relationship despite years of problems, and dealing with problems that accumulated when the IP was drinking also are challenges. It is often helpful to empathize with either partner's occasional feelings of despair and frustration, while at the same time imparting positive expectancies, a sense of normality regarding the struggle, and (most of all) hope.

Assessment and Treatment Planning

Overview of Diagnostic/Assessment Procedures

The primary goals of assessment are to evaluate the immediate needs of the couple; assess the extent and severity of the drinking problem to determine the appropriate level of care; identify antecedents to drinking, consequences maintaining the drinking, cognitive and affective aspects of the drinking, and positive and negative aspects of the IP's drinking-related behavior; and assess problem areas, strengths, and weaknesses in the couple's relationship. Several assessment strategies are used to complete a comprehensive evaluation for case conceptualization and treatment planning, including intensive interviews, self-report questionnaires, observation of interactional behavior, self-monitoring cards, and physiological measures (e.g., blood alcohol levels, tests of liver functioning, and urine screens for drug use).

Specific Assessment Procedures

For combined research and clinical purposes, our assessment includes semistructured standardized interviews and self-report questionnaires that typically take about 4 hours and are spread across two conjoint assessment sessions, except for IPV assessment. The assessment focuses on diagnosis, history, and severity of the alcohol problems and recent consumption; motivation and drinking goals; partner coping with the drinking; and relationship satisfaction, communication, commitment, and conflict resolution skills. General psychosocial functioning, psychiatric status, and social network also are assessed. In clinical practice, the therapist can limit the assessment to the clinical intake interview and give the partners questionnaires to complete at home.

Each assessment and therapy session starts with clinician administration of a Breathalyzer test or alcohol saliva strip. The therapist explains that this is a routine procedure to ensure that an IP is sober because intoxication makes it difficult to think clearly or benefit fully from the sessions. This testing serves to educate clients and to model clear, reasonable limit setting. For IPs with drug problems, we use onsite urine or saliva screens to test for other drugs.

The clinical interview proceeds with questions about what led the couple to seek treatment, how they each perceive the drinking problem, how the problem has affected them, and whether there are other problems that concern them. The therapist also may inquire about each partner's family history of alcohol use and other psychiatric disorders; the IP's frequency, quantity, and types of alcohol/drugs used; family environment; motivation for change and drinking goals; other psychopathology; relationship functioning; and IPV. The alcohol module of the Structured Clinical Interview for DSM-5 Disorders (First, Williams, Karg, & Spitzer, 2013) typically is administered, as well as the Drinker Inventory of Consequences (Miller, Tonigan, & Longabaugh, 1995). The clinician also may administer the Timeline Followback Interview (TLFB; Sobell & Sobell, 2003) to obtain an estimate of the IP's drinking in the 3 months prior to treatment.

Each partner is asked to complete the Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugerman, 1996), and the therapist then meets individually with each partner to query about any history of violence in the home, whether violence was secondary to drinking, and whether each partner feels safe in couple therapy. If moderate to severe physical violence has occurred and/or if either partner feels unsafe in couple therapy, the couple is not appropriate for conjoint therapy and should be offered other services or referred appropriately (see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich).

We also ask both partners whether they have concerns about other areas of life functioning. Also, how the SO has coped with the drinking is assessed through interview and self-report questionnaires such as the Coping Questionnaire (Ahuja, Orford, & Copello, 2003). Finally, the therapist begins to evaluate the couple's relationship by observing their interactions during the interview and begins to formulate hypotheses about strengths and problems in their communication. The partners complete self-report questionnaires to assess relationship satisfaction and content areas in which they want behavior change from each other, such as the Dyadic Adjustment Scale (Spanier, 1976) and the Areas of Change Questionnaire (Margolin, Talovic, & Weinstein, 1983).

Case Formulation and Treatment Planning

ABCT has three targets of intervention—IP drinking, SO responses to drinking and support for IP change, and the couple's relationship. Consequently, case formulation and treatment planning address these three areas, as well as other issues (e.g., psychological functioning). Even if the clinician follows a structured treatment protocol, the content of the treatment sessions is guided by the case formulation. To develop a cognitive-behavioral/motivational enhancement formulation and treatment plan related to the drinking, the clinician addresses several questions: (1) What is maintaining the IP's drinking problem? To what degree do physical dependence, psychological issues, and interpersonal issues appear to maintain the drinking, and what level of care is indicated to achieve initial abstinence? (2) What are the IP's major triggers? (3) What positive consequences are most important in maintaining the drinking, and what negative consequences might serve as sources of motivation to change? From these questions, the clinician identifies major antecedents and consequences that contribute to maintaining the drinking and develops a plan to help the IP decrease or stop drinking, acquire cognitive, behavioral, and emotion regulation coping skills to deal with major antecedents to drinking, maintain positive motivation to change, and find alternative means to obtain positive reinforcers from sources other than alcohol.

To develop a cognitive-behavioral formulation and treatment plan for the SO's responses to drinking, the clinician addresses a second set of questions: (1) How effectively is the SO coping with the drinking? (2) In what ways does the SO's behavior serve as a trigger for the drinking? (3) In what ways does the SO reinforce the drinking? (4) In what ways does the SO create appropriate consequences for the drinking? Developing answers to these questions helps the clinician understand what SO behaviors contribute to the maintenance of drinking. The clinician helps the SO learn appropriate means to support the IP's efforts to change, reinforce positive behavior change and respond effectively to negative drinking-related IP behaviors, change behaviors that may serve as triggers for drinking, and learn self-care skills.

The third part of the case formulation and treatment plan addresses the couple's functioning:

1. To what degree are the partners working collaboratively or against each other in coping with drinking?
2. How is the couple functioning as a collaborating unit?
3. Is the overall quality of the relationship more positive or more negative?
4. To what degree do the partners support each other?
5. What are specific communication strengths and deficits?

From these questions, the clinician conceptualizes the couple's unique strengths and deficits and formulates interventions to help them learn how to work collaboratively to deal with alcohol, enhance positive reciprocity, and determine what communication skills appear most important to focus on in the sessions.

Goal Setting

Traditional approaches to AUD treatment view abstinence as the only appropriate drinking goal. The alcohol problems perspective and contemporary definitions of "recovery" (Holzhauer, Cucciare, & Epstein, 2020) provide a more flexible approach to client goal setting when clinically appropriate. Some alternatives to abstinence and strategies to teach clients how to drink moderately (e.g., Kranitz & Cooney, 2013) suggest the use of moderate drinking goals to help reduce potential harm from heavy drinking among clients not willing to consider abstinence as a goal, or who are deemed to be at lower risk for severe alcohol-related problems.

The ABCT model emphasizes abstinence as the preferred drinking goal for treatment. Most of our clients have experienced serious medical, social, legal, or occupational consequences of their drinking. The potential for problems if they continue to drink is substantial. Second, we believe that many persons with AUD overvalue alcohol, underestimate the seriousness of the consequences of their drinking, and/or overestimate the negative aspects of abstinence. With such clients, we believe that part of the therapist's responsibility is to help the IP make a more realistic appraisal of the positive and negative consequences of drinking and abstinence, which is best done during a period of abstinence. Third, couples often enter treatment at the specific request of the SO, who may not agree to a goal of moderation. We ask clients to commit to an initial goal of abstinence for a mutually agreed-upon period. For IPs with medical sequelae of drinking or a diagnosis of a severe AUD, we stress the importance of continued abstinence. For other IPs, we may define abstinence as a provisional goal that allows them to be "clear-headed" during treatment and gives them the opportunity to evaluate the experience of abstinence before making a longer-term decision about their drinking goals. Most IPs agree to abstinence given the provisional rather than absolute nature of the goal. However, if a couple is committed to a goal of reduced drinking, we work with them rather than turning them away from treatment.

In addition to drinking-related goals, several other major goals for the treatment include developing coping skills to deal with alcohol-related situations (for both partners), developing positive reinforcers for abstinence or changed drinking, enhancing relationship functioning, developing general coping skills, developing effective communication and problem-solving skills, and developing strategies to maintain therapeutic gains and deal with relapses. Other couple-specific goals may also be identified. The content of these goals is decided collaboratively between the therapist and the couple.

Process and Technical Aspects of Couple Therapy

Overview

Our conceptualization of drinking problems necessitates intervening at multiple levels—with the IP, the SO, the relationship as a unit, and, indirectly, with the family and other social systems in which the IP is involved. Implicit in the model is the need for detailed assessment to determine the primary factors contributing to the maintenance of the drinking, the skills and deficits of both individuals and the couple as a unit, and the sources of motivation to change. As in any cognitive-behavioral model, skills training, behavioral rehearsal in session, and between-sessions homework assignments are intrinsic to

ABCT. In addition, any alcohol treatment must attend to the physiological aspects of alcohol use and AUD, providing psychoeducation about the nature of physical dependence and withdrawal, standard drinks, and blood alcohol levels. The following sections describe interventions for each of the three foci of treatment; however, all three elements are integrated into each treatment session (see Table 25.1), so that change strategies are being introduced consistently to both partners and to the couple as a unit.

Interventions for the IP

At the individual level, the treatment starts with a plan to help the IP become abstinent from alcohol (if still drinking) and to enhance motivation for change. Functional analysis is used to help identify antecedents to drinking, potential and actual reinforcers for continued drinking and for decreased drinking or abstinence, negative consequences of drinking and abstinence, and beliefs and expectations about alcohol use and its consequences. Individual interventions focus on skills to cope with alcohol-related situations, such as self-monitoring of drinking and drinking urges, self-management planning, stimulus control, and drink refusal. Behavioral and cognitive coping skills that are taught to couples to handle psychological and interpersonal antecedents to drinking and to develop a nondrinking lifestyle include assertiveness, managing negative affect, cognitive restructuring, relaxation, lifestyle balance, and recreational activities. Toward the end of treatment, we focus explicitly on relapse prevention. All interventions focused on the IP are introduced with both partners in the room; the SO is invited to contribute ideas, feedback, and ways to support behavior change.

ABSTINENCE PLANNING

IPs who are drinking at the start of treatment need a clear plan to achieve initial abstinence. IPs with a history of severe withdrawal symptoms such as seizures, hallucinations, or delirium, and/or medical problems that could complicate withdrawal should be counseled to stop drinking only under a physician's care and typically are referred to inpatient detoxification. IPs with a history of significant but not severe withdrawal symptoms and no complicating medical problems may be detoxified with medication taken on an ambulatory basis. Generally, IPs who are drinking heavily and daily for a long period of time (i.e., reaching blood alcohol levels of approximately 0.15 or higher on a daily basis) are counseled to seek inpatient or ambulatory detoxification, and are warned against simply stopping "cold turkey" while not under medical care. IPs who do not meet these withdrawal risk criteria may elect to stop drinking abruptly and suffer more minor withdrawal symptoms (e.g., insomnia, anxiety, irritation, nausea), or may work with the therapist on a plan to decrease drinking gradually over a few days to 1–2 weeks (Holzhauer et al., 2017). Except for IPs with a history of severe withdrawal symptoms, the therapist discusses withdrawal options with the couple and helps them weigh the pros and cons of each choice. The therapist should be familiar with medications available to help clients maintain abstinence after detoxification (naltrexone, extended-release naltrexone, acamprosate, and disulfiram) and recognize when such medications might be helpful.

MOTIVATIONAL ENHANCEMENT

A focus throughout the therapy is on enhancing and maintaining IP and SO motivation for change. Motivational models suggest that individuals initiate change when the perceived costs of the behavior outweigh the perceived benefits, and when they can anticipate some benefits from behavior change. We view motivation as a state that can be influenced by therapeutic behaviors and the clients' life experiences (Miller & Rollnick, 2013). Recognizing clients' degree of readiness to change, using motivational enhancement techniques, adopting the spirit of motivational interviewing (Miller & Rollnick, 2013), and using a nonconfrontational therapeutic style are all parts of the ABCT approach. Specific techniques include feedback in the first session about the IP's drinking severity and consequences, and later use of a decisional balance framework to help both partners assess the pros and cons of abstinence versus continued drinking.

ALCOHOL-FOCUSED COPING SKILLS

Several core coping skills help IPs change their drinking. The individually focused elements of ABCT help the IP acquire these skills. Beginning with the first treatment session, both partners are introduced to daily self-monitoring cards. The IP tracks (in real time) drinks, drug use, drinking urges, and relationship satisfaction; the SO tracks their own daily relationship satisfaction and makes a daily estimate of the IP's drinking (none, light, moderate, or heavy) and intensity of drinking urges. These cards are collected at the beginning of each session, and the therapist provides graphical feedback on drinking quantity, frequency and intensity of drinking urges, and each partner's relationship satisfaction over the past week. There also are several smartphone apps to track drinking, if preferred. Two useful apps are the AlcoDroid tracker (*https://play.google.com/store/apps/details?id=org.m.alcodroid&hl=en*) and DrinkControl (*https://drinkcontrolapp.com*), but many others have been developed, and our clients have been creative in finding apps that they find useful. When the partners have recorded discrepant information about drinking, the therapist uses these discrepancies as opportunities for discussion. If the IP or SO did not complete their cards during the week, the therapist fills in the cards in the session with them and problem-solves to address obstacles to completing the cards.

Using information from the clinical interview, discussion in session, and self-monitoring cards, the therapist helps the IP identify high-risk situations for drinking and introduces the functional analysis (behavior chain). The therapist then introduces self-management planning to help the IP develop alternative coping strategies for environmentally focused high-risk situations. Additional alcohol-focused coping skills focus on managing drinking urges and alcohol-related thoughts, obtaining some of the positive consequences previously obtained from alcohol through alternatives, and refusing drinks. These interventions include discussions of ways the SO can be supportive in potential drinking situations or when the IP experiences drinking urges.

GENERAL COPING SKILLS

The therapist may introduce ways to cope with negative affect, such as relaxation, assertiveness training, or cognitive restructuring. The therapist also may focus broadly on means to obtain a more desirable balance among work, family, and recreation. All of these areas are addressed by using cognitive-behavioral skills training techniques.

OTHER SOCIAL SYSTEM INTERVENTIONS

The IP and SO are helped to identify interpersonal situations and persons associated with heavy drinking; they also are helped to identify potential social situations and individuals that would be supportive of abstinence or decreased drinking. IPs may be encouraged to become involved with Alcoholics Anonymous (AA) or other mutual-help programs, such as Self-Management and Recovery Training (SMART® Recovery). Mutual-help groups provide a strong social support network for abstinence, opportunities to meet abstinent individuals, and time-structuring activities incompatible with drinking.

RELAPSE PREVENTION

Since the mid-1980s (Marlatt & Gordon, 1985), the alcohol treatment field has recognized the importance of focusing explicitly on the possibility of posttreatment relapse and ways to prevent and manage relapses. The explicit relapse prevention modules in ABCT introduce both partners to the fact that most IPs drink again after treatment and to specific relapse prevention strategies. We introduce the idea that decisions apparently unrelated to drinking ("seemingly irrelevant decisions"; Marlatt & Gordon, 1985) may set the stage for drinking, then use specific exercises to help both partners identify possible warning signs for relapse and plans to respond to these warning signs. Finally, we help the couple discuss appropriate individual and couple steps that may be helpful if a drinking episode should occur.

Interventions for the SO

The second set of interventions revolves around the coping behaviors of the SO. The SO's motivation for entering and continuing in treatment and perceptions of positive and negative consequences of changes in drinking and in the couple relationship all contribute to the SO's willingness to be an active participant in the therapy and try out new behaviors. ABCT provides opportunities for the SO learn coping skills to deal with drinking and abstinence, based on an individualized assessment of the SO's behaviors that may cue and/or maintain drinking. Coping skills for the SO may include new ways to discuss drinking and drinking situations, new responses to the drinking and alcohol-related behavior, or individual skills to enhance the partner's own individual functioning.

ALCOHOL-FOCUSED COPING SKILLS

The SO is integrally involved in all of the ABCT interventions. In the first session, some of the feedback focuses on ways the SO has attempted to cope with the drinking. From the beginning of treatment, the SO is encouraged to provide simple behavioral responses that can support changes in the IP's behavior. The SO then learns to identify their own behaviors that may serve as cues for drinking, and alternative approaches to these situations, and also ways to decrease attention to drinking and to decrease behaviors that may protect the IP from naturally occurring negative consequences of drinking. The IP is integrally involved with these interventions, providing feedback about behaviors that would be most supportive and helpful.

RELAPSE PREVENTION INTERVENTIONS

As part of the relapse prevention interventions, the SO is helped to identify specific behaviors that would be signs that they are returning to behaviors that do not support the IP's drinking goals. As with the IP, the therapist then helps the SO to develop strategies to respond if these behaviors should occur.

Couple-Focused Interventions

The third component of ABCT focuses on the couple as a unit. Early in treatment, the therapist uses discussion about alcohol-related behaviors as a vehicle for each partner to work on basic communication skills, such as listening without interrupting or making specific positive suggestions for change. As treatment progresses, couple-focused interventions address ways to increase positive exchanges and develop more communication and problem-solving skills.

RECIPROCITY ENHANCEMENT

Reciprocity enhancement exercises are designed to increase positive exchanges. Interventions early in therapy ask each partner to notice positive behaviors by the other partner ("notice something nice") and to note these on the back of the self-monitoring cards. At first, the therapist helps the partners give each other feedback in the session about some of the behaviors noted. Over time, they are encouraged to provide this feedback at home. The therapist also helps the couple identify and implement positive shared activities as a way to build the positive value of the relationship for both partners.

ALCOHOL-SPECIFIC COMMUNICATION AND PROBLEM-SOLVING

Discussion of alcohol-related topics is used as a vehicle to introduce communication and problem-solving skills. Topics may include how the couple can manage a situation where alcohol is present, whether or not to keep alcohol in the house, how the SO can assist the IP in dealing with urges to drink, or what the couple will tell family and friends about the IP's drinking or treatment. By helping the couple discuss these topics in session, the therapist introduces the couple to basic communication skills.

GENERAL COMMUNICATION AND PROBLEM-SOLVING

Communication training occurs informally throughout the treatment; formal communication skills training is introduced after the IP has made successful changes in drinking and the couple has addressed some alcohol-related couple issues. Communication skills training is conducted with the couple similarly to cognitive-behavioral communication training with any distressed couple (see also Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom et al.); it includes an introduction to communication, reflective listening skills, leveling and editing, and problem solving. The communication interventions combine didactic education about communication with helping the couple practice skills in session that address the particular couple's skill deficits and then having them practice these skills at home.

RELAPSE PREVENTION INTERVENTIONS

The couple-focused relapse prevention interventions help the partners talk together about potential signs that their relationship is "relapsing," as well as ways to respond if these relapse warning signs should arise.

MAINTENANCE OF CHANGE

The treatment model is designed explicitly to include techniques to increase generalization to the natural environment and maintenance of new behaviors. Homework assignments, teaching clients how to anticipate high-risk situations, and planned follow-up treatment sessions are all designed to contribute to maintenance of change.

Tailoring Treatment to Different Couple Presentations and Needs

ACUTE COUPLE DISTRESS

It is often not constructive to proceed with structured therapeutic exercises when partners are extremely angry with each other in session and are unable to redirect. The therapist may try several techniques to "bring down the temperature," such as providing basic communication skills training (e.g., stressing that each partner must let the other finish before speaking, or modeling respectful communication); helping the couple define and refocus on common goals related to the drinking; or setting limits about in-session behavior. Sometimes a detour is useful to help the couple address the anger and/or a bit of the angry topic; then remind the couple that the therapy protocol is progressive and will address communication skills and difficult topics more fully in later sessions. If the level of anger is consistently derailing the sessions and not getting better over time, the therapist may consider separate therapy for each partner as an alternative to conjoint therapy if the couple is not able to work together.

If either partner reports physical violence at home, then this must be addressed. The therapist must first determine whether conjoint therapy is still appropriate. If the IP is motivated to stop drinking, the violence occurred only during drinking episodes, and the abused partner is not concerned about retribution for topics discussed in therapy, couple therapy can be continued. If the violence occurs independent of drinking, the IP is not motivated to stop drinking, or the abused partner expresses concerns about personal safety, conjoint therapy is contraindicated. Even if therapist and couple decide to proceed with couple therapy, a basic safety plan should be developed for the abused partner, and an agreement should be made to remove weapons from the home. A cognitive-behavioral treatment model of IPV (see Chapter 17 on partner aggression, in this volume, by Epstein et al.) can be used, although the therapist must take into account that, in most cases, intoxication will be a primary “high-risk” situation for the violence.

MULTIPLE DRUG USE

The prevalence of comorbid SUD in treatment populations with AUD hovers around 50% for males and 40% for females (Rosenthal, 2013). Thus, an IP who comes for conjoint therapy for an AUD must be evaluated carefully for other drug use. Other drug use can complicate the therapy in several ways.

1. Abstinence from alcohol may result in the IP seeking new drugs to cope, or in increased use of other drugs the IP already uses. New problems related to the other drugs may then arise.
2. It may be difficult to link negative consequences specifically to either alcohol or other drugs.
3. Different approaches may be needed to detoxify the IP from different drugs.
4. Using other drugs may create “high-risk situations” for alcohol use.
5. An IP who is abstinent from alcohol but using other drugs may continue to use substances as a coping mechanism, creating an increased risk for relapse.
6. Couple issues are complicated by other drug use if the partners have different expectancies about those drugs.

For these reasons, it is typically better to address all drugs used, not just the ones either partner dislikes. Strategies for dealing with other drug use vary, depending on the nature of each substance and its negative consequences. (For further guidance on treatment of other SUDs, see McCrady & Epstein, 2013.)

OTHER COMORBID PSYCHOPATHOLOGY

As noted, a high percentage of individuals with AUD have other psychiatric problems concurrent with, antecedent to, or resulting from their alcohol problems. Rates of psychopathology among persons with AUD are much greater than in the general population and have several implications for treatment. First, assessment should include screening for comorbid disorders, even though diagnosis is difficult when an IP is actively drinking. If the IP appears to have serious comorbid psychopathology, it may be necessary to delay alcohol treatment until the other problem is stabilized, or to provide concurrent treatment for both problems. It also is important to work closely with other treatment providers to address comorbid psychopathology. The therapist should be trained in identifying comorbid disorders and be familiar with current psychological and pharmacological treatment options for these problems. The therapist then will be able to provide appropriate referrals as necessary, and also weave in some attention as clinically appropriate to the symptoms of the comorbid problems as triggers to use alcohol or to symptoms worsened by alcohol use.

WHEN BOTH PARTNERS HAVE A DRINKING PROBLEM

The conjoint model can be modified to allow treatment of both partners’ drinking problems, if needed. Such treatment, however, may necessitate a longer therapy program than described previously because cognitive-behavioral skills will have to be covered for both partners. The partners will almost certainly benefit from sharing and watching each other go through the process of change, but they also will be challenged to learn how to reinforce each other's sobriety, eliminate partner-related triggers, and cope jointly with alcohol-related situations. Sometimes other issues need to be addressed, such as possible differences in level of motivation for change, the development of support systems for abstinence outside the couple relationship, differences in the partners' level of support for each other, and difficulty in both giving support to and receiving it from a partner while trying to change one's own drinking or drug use.

ADAPTING ABCT FOR DIVERSE COUPLES

To date, there has not been an explicit approach to adapting ABCT for clients from diverse racial and ethnic backgrounds. Most of the research on ABCT has used predominantly White, mixed-gender couples, and there has been limited consideration of age-related diversity. Couples from racial or ethnic minority groups, as well as same-gender couples, face intersecting challenges related to their own cultural and racial identities, perceptions of gender roles, the experience of stigma and prejudice, as well as, for some couples, a range of socioeconomic challenges such as poverty, residential segregation, and disparities in access to health care (McCrady & Flanagan, 2021; Wagner & Baldwin, 2020). Couples also may be diverse in terms of age (e.g., couples in their teens to early 20s vs. older adults), and veteran status. Therapists providing ABCT to couples from diverse backgrounds can draw on general principles of couple therapy with diverse populations (see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim), be knowledgeable about the cultural and relationship values of relevance to each couple and personalize the treatment to be responsive to each couple's unique identities.

In addition to general principles of working with diverse patients and couples, there are clinical considerations specific to couples with AUD that are important for treatment planning. For instance, specific racial, ethnic, cultural groups, and age-specific groups have particular social norms and expectations for what constitutes "normal" alcohol use, and partners from different backgrounds (as well as the therapist) may have different goals or expectations for treatment. Alcohol use, heavy drinking, and use of other substances can range from integral and normative in one culture, to stigmatized and shamed in another culture, and couples may vary widely in the degree to which the drinking norms of their subculture are central to their own identities. Additionally, factors related to minority stress such as internalized stigma, discrimination, and victimization can act as risk and maintenance factors for AUD. These factors may need to be addressed with the couple, for example, as triggers for alcohol use in treatment. The ABCT therapist must always focus on what makes an individual's drinking problematic within the relationship, and this includes understanding each partner's cultural identities and daily experiences. To be a successful ABCT therapist, it is important to avoid making assumptions regarding both partners' goals, expectations, and beliefs.

Common Therapist Errors

There are several common therapist errors in working with AUD couples. First, therapists may underestimate the complexity of an IP's psychological problems. The importance of assessing and appropriately treating co-occurring disorders cannot be emphasized enough. If other health care professionals are involved with treatment, it is essential that the clinician confer with these professionals. If clients are involved with other systems, such as the legal system or child welfare, clinician contact (with appropriate consent) with these agencies also is important to the overall planning and execution of the therapy.

A second common source of therapeutic error relates to an IP's use of other psychoactive drugs. As noted earlier, careful assessment of the IP's use of other drugs, consideration of the degree to which that use is impairing or potentially impairing the IP's or the couple's functioning and understanding the functional relationship between alcohol use and other drug use are important first steps. Attention to motivational issues related to other drug use helps the therapist to determine the degree to which the use of other drugs will be a focus of treatment.

A third common error is either over- or underestimating either partner's motivation to change. We assume that every couple enters treatment with ambivalence about change. Alcohol is familiar and has provided many positive experiences in the past; not drinking requires a new set of unfamiliar skills and experiences. The therapist who ignores this fundamental ambivalence will have difficulty in the therapy. Conversely, clinicians may err at times by spending too much time on motivational enhancement, not realizing that some of the clients' difficulties in achieving change relate to skills deficits rather than motivational issues.

A fourth common therapist error is overestimating clients' skills. Many individuals with AUD have good verbal skills that cover significant cognitive deficits in abstraction and problem solving (resulting from long-term heavy alcohol intake) (Sullivan & Pfefferbaum, 2019). A therapist may not see these deficits in the therapy session and may assume that an IP can apply concepts to situations outside the therapy without detailed discussion, explanation, and planning. The more concrete, detailed, and specific the therapist is, the more effective the therapy will be.

A fifth common therapeutic error is to underestimate the degree of anger or other "toxic" pathology in a couple. In some couples with drinking problems, the partners may appear superficially to be committed to each other but at the same time have a wealth of anger based on years of disappointment, hurt, and vicious interactions. Some such partners begin therapy with a rather positive stance, but after several sessions, the degree of the negative feeling between them becomes much more apparent and undermines therapeutic progress.

A sixth common therapist error is to allow a couple to avoid homework or avoid discussing or dealing with alcohol-related issues. Although some couples are highly compliant with homework assignments, others do not complete assignments, forget them, or attempt to avoid discussing them in the treatment session. Since such a pattern of avoidance and lack of follow-through on commitments may be characteristic of a couple's relationship, allowing the couple to engage in the same behavior in therapy undermines the therapist's credibility and deprives the couple of the opportunity to have a different learning experience in therapy.

A final and common technical error is for the therapist to ally with the SO against a noncompliant IP. Such an alliance probably ensures that the therapy will not be successful.

Termination

Termination raises an interesting problem in the context of alcohol treatment because AUD is often a relapsing disorder that requires continued or intermittent treatment. Currently, ABCT is time-limited, with the option of "booster" or maintenance sessions continuing for as long as the involved parties see fit. The therapist also might refer the IP to some form of continuing care (ongoing monthly or as-needed booster sessions) or a mutual help group such as AA or SMART Recovery after ABCT. In addition to the ongoing support these programs may provide for the IP, there are couples' AA meetings that some of our clients have found helpful.

Two major criteria should be used to assess when it is time to terminate a successful course of treatment. First, the therapist should consider whether the IP has resolved their alcohol use. Criteria to consider include (1) maintenance of a drinking goal for a sufficient length of time for the IP to feel comfortable with the change, (2) cravings and urges for alcohol have decreased and become manageable, (3) other pleasurable activities to replace drinking are in place, and (4) social supports are in place to support abstinence. Second, the therapist should consider whether the couple's relationship has improved. Criteria to consider include (1) reports by both the IP and SO of greater satisfaction with their relationship; (2) in sessions, evidence of increased good will toward each other; (3) evidence of better communication and more effective problem solving; and (4) evidence that both partners have adjusted to role changes in their relationship.

If these criteria are met, and if the therapist feels comfortable that they have introduced the key skills for the couple, the process of terminating the intensive weekly portion of the therapy can begin. One way to ease termination and to help the couple continue to discuss issues regularly is to introduce the concept of "couple meetings," and have the couple practice these meetings in sessions and as homework between sessions toward the end of therapy. In general, ABCT is structured to facilitate a smooth transition to termination because it is skills based, emphasizes between-session practice, and relapse prevention is built into the sessions.

MECHANISMS OF CHANGE

Early research examining how ABCT works (mechanisms of behavior change, MOBC) focused on pre- to posttreatment self-reported behavior. These early studies suggested that use of SO skills is associated with better patient drinking outcomes (e.g., O'Farrell, Choquette, & Cutter, 1998). ABCT leads to greater relationship satisfaction (e.g., McCrady, Noel, Stout, Abrams, & Nelson, 1991), dyadic behaviors and drinking outcomes are related (McCrady, Hayaki, Epstein, & Hirsch, 2002), and improved relationship functioning may precede reductions in drinking (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004). These findings support the importance of both teaching skills to the SO and addressing relationship issues during the treatment.

More recent research has examined verbal behaviors during ABCT sessions to better understand how these behaviors may lead to positive outcomes. Taken as a whole, these studies have suggested key aspects of IP and SO verbal behavior that relate to positive outcomes and that might be important for therapists to attend to during treatment sessions. First, the pronouns that IPs and SOs use in sessions are important. Greater use of language that encompasses the couple (e.g., "we," "our") rather than individually focused language (e.g., "I," "mine") predicts positive outcomes (Hallgren & McCrady, 2016). Therapists might try to coach couples toward "we" language in their communications with each other. Second, IP language about changing or not changing their drinking predicts the outcomes of treatment. Therapists should listen carefully for IP statements about positive change, and support and reinforce these statements (McCrady et al., 2019). Third, how the SO talks about change also appears to be an important verbal behavior to attend to. Early in treatment, IPs often respond to SO change talk by decreasing their own statements of reasons to change during the session (Fokas, McCrady, & Houck, 2020). Therapists should be sensitive to this dynamic and perhaps help the couple discuss the IP's reaction to the SO's encouragement of change. Finally, certain couple interactions appear to predict poorer drinking outcomes (McCrady et al., 2019). Specifically, frequent SO advice to the IP and IP expressions of contempt toward the SO appear to have a particularly negative impact on drinking outcomes. Therapists should listen carefully for both of these kinds of behaviors and intervene to direct the couple toward more constructive forms of communication.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Applicability and Indications

ABCT is most appropriate for persons with AUD in stable couple relationships with partners willing to be involved in treatment, who can function in a supportive manner in the early phases of treatment. Additional positive indicators for conjoint therapy for IPs are (1) having a high school education or better, being employed, and still living with their SOs; (2) drinking problems that are serious and of longer duration; (3) being older; (4) successful periods of abstinence in the past; and (5) past alcohol-related legal problems. Couples with severe IPV, couples with a court-issued restraining order, couples in which one partner's commitment to the relationship is highly ambivalent, and couples with a male IP who has severe individual psychopathology are less appropriate for couple therapy (McCrady et al., 2016). However, with women, ABCT has been found to be more effective than individual cognitive-behavioral therapy for women with co-occurring disorders (McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009).

Contraindications and Limitations

ABCT was developed as an outpatient treatment model and has been used successfully as a stand-alone treatment. However, sometimes an IP (or SO) requires a higher level of care, and ABCT should be either suspended if the IP is not improving or offered as an aftercare option after more intensive treatment. For example, if an IP is not having success in stopping or substantially decreasing drinking by the fifth session (e.g., Hildebrandt, McCrady, Epstein, Cook, & Jensen, 2010), it may be wise to consider more intensive treatment. If either partner presents with worsening depression, anxiety, or increased use of other drugs, it may be advisable to refer them for psychotropic medication, a residential or intensive outpatient substance abuse treatment program, and/or a dual-diagnosis treatment program.

A different limitation of ABCT involves the complicated nature of the cases seen and the need to focus on so many levels of treatment. Several factors can render what seems an overwhelmingly complicated case manageable, including (1) the use of good diagnostic tools at the start of treatment; (2) access to an excellent referral network including addiction medicine specialists, more intensive AUD treatment, other social service resources, and physicians competent to treat patients with AUD; and (3) skills to know when and how to access other resources. Additionally, it is helpful to have a good support network of colleagues with whom to consult and from whom to obtain support in dealing with these complicated couples.

Empirical Support

Researchers typically look at drinking and relationship satisfaction as key indicators of treatment outcome, and research findings suggest that ABCT results in significant reductions in alcohol consumption and improvements in couple functioning in IPs with moderate to severe AUD (reviewed in McCrady et al., 2016). Some research has examined ABCT with IPs with less severe drinking problems and their partners, with promising but mixed results (Bouma, Halford, & Young, 2004; Walitzer & Derman, 2004). Research also has suggested that ABCT leads to reductions SOs' alcohol use (Kuenzler & Beutler, 2003) and partners' relationship satisfaction (Vedel, Emmelkamp, & Schippers, 2008).

Clinical researchers have continued to develop and study new applications of the basic ABCT treatment, with investigators applying the model to couples with SUDs other than AUD, couples affected by AUD and posttraumatic stress disorder (PTSD), women with AUD, and military veterans (reviewed in McCrady & Flanagan, 2021). Narrative reviews (McCrady et al., 2016) support the efficacy of partner-involved therapy over treatment for a client with an AUD alone, if there is a partner who is willing to participate in the treatment. However, it is difficult to engage partners in treatment at times, and one study that gave women a choice of individual or couple therapy found that women overwhelmingly preferred individual treatment, citing their desire to work on individual problems, a lack of perceived support from their partners, and logistical issues as reasons (McCrady, Epstein, Cook, Jensen, & Ladd, 2011). Given the strength of the findings about the efficacy of ABCT for women, therapists should consider advising a conjoint approach even for women with AUD who are hesitant to involve their partners.

CASE ILLUSTRATION

The case described here captures key elements of ABCT treatment; the couple completed 15 sessions, rather than 12, due to comorbid psychiatric problems of the IP.

Identifying Information and Presenting Problem

Andrew (a 37-year-old White male) and Erin (a 36-year-old White female) had been married for 14 years. They had two children, a 13-year-old boy, Grant, and 9-year-old girl, Ashley. They worked full-time, Andrew as a heating, ventilation, and air-conditioning technician and Erin as a nurse. The couple was referred to our program by Andrew's primary care physician (PCP), who had previously referred him to a 7-day detoxification (detox) program for AUD. Andrew had completed detox 5 months before their first ABCT meeting, and while he had attended AA for a brief time after, he quickly relapsed to regular alcohol use. Erin agreed to attend treatment with Andrew because she was worried about his health, and because of his worsening mood.

Assessment

Andrew and Erin underwent an evaluation. The therapist took a personal history, focusing on the couple's relationship and the progression of Andrew's AUD. Andrew had graduated high school, completed a year of college, then enlisted in the National Guard at age 20. Andrew reported drinking in a binge-like fashion while in college and in the National Guard. He also started to experience depression symptoms at that time. "It was a hard time. On weekends when I wasn't at Guard Drill, I would sleep until 4 o'clock, go out with friends, and start drinking. Everything felt pointless." Erin and Andrew married after dating for 2 years, when they were 22 and 23, respectively, and Andrew's drinking increased in frequency after they moved in together.

Grant was born a year later, and Andrew stopped drinking for a 3-year period. "Erin worked nights, so I watched the baby in the evenings. I was a lot happier at that time." Andrew was then deployed to Afghanistan for 6 months and had worsened depression upon his return. "Erin had figured out how to manage on her own, and Erin's mom had moved in to help with Grant. That just continued after I returned. I felt like I had after college—just useless." Andrew started drinking again, having a few beers nightly and going out with coworkers. Their daughter was born when Grant was 5. "After Ashley was born, I would go home right after work, but Erin's mom was always there, and Erin had stopped working nights. I'd get home and just start drinking. Why not?" As Andrew spoke, Erin became tearful. She said she had no idea that was how he had been feeling.

In completing the TLFB (Sobell & Sobell, 2003), Andrew reported drinking seven standard drinks of beer every night; however, that reflected a decrease since detox. Prior to detox, he was drinking nine standard drinks on weeknights and 15 on weekends, starting with beer and transitioning to whiskey. About once a week, he would add whiskey to coffee while at work. When he described this, Erin was shocked. “I had no idea it was so bad . . . I thought the doctor was overreacting.” At the intake, Andrew met DSM-5-TR (American Psychiatric Association, 2022) criteria for severe AUD, endorsing all 11 AUD symptoms. Erin reported having one to two standard drinks once a month and denied any other substance use, although a formal evaluation was not completed. Andrew scored a 32 on the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996), indicating severe depression, and Erin scored a 20, indicating moderate depression. Andrew reported that his most bothersome symptoms were insomnia, decreased appetite, feeling like a failure, and irritability. The therapist determined that ABCT would be appropriate for the couple.

The therapist met individually with each partner to assess IPV, with both partners denying physical, emotional, or verbal abuse. During the initial interview, the therapist observed the couple’s interactions. It was clear from their self-report measures, communication, and body language (e.g., holding hands during the session) that they were committed to the marriage. However, each partner wanted change in terms of engagement and communication. The therapist noted their tendency toward avoidance in communication. “This is the first time we’ve dealt with anything major,” Erin noted. “I guess that’s part of the problem.”

Therapy Sessions 1–2

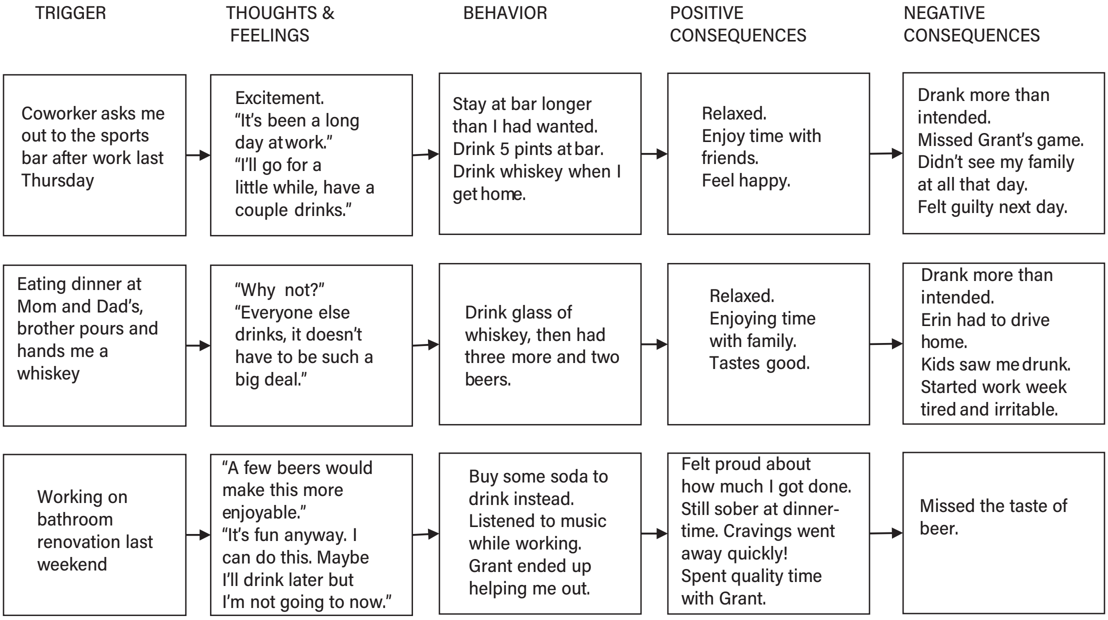
The first two therapy sessions focused on rapport building, creating an abstinence plan, and understanding the antecedents and functions of Andrew’s alcohol use. In Session 1, the rationale for a couple-based approach to treating AUD was provided. The therapist summarized information collected during the assessment, including Andrew’s drinking patterns, and provided information about what constitutes unhealthy alcohol use. They reviewed the negative consequences of Andrew’s drinking. Andrew was asked to begin tracking his alcohol use, alcohol cravings, relationship satisfaction, and overall mood on daily diary cards; given his insomnia, his therapist also asked him to track his sleep. Erin was asked to track her relationship satisfaction and mood. The therapist began having the couple identify potential high-risk situations for drinking in the next week and establishing a coping plan. Andrew expressed his desire to stop drinking altogether and options for an abstinence plan were reviewed. The therapist and Andrew collaboratively decided to use a “wind down” plan, which would also serve to avoid withdrawal symptoms. The therapist, Andrew, and Erin worked on setting a quit day. Andrew measured his drinks, recorded drinks on his daily diary logs (self-monitoring cards) and reduced the daily number of drinks over the next 2 weeks, having one less drink every 1–2 days.

The second session addressed goal setting and functional analysis (behavior chains). His abstinence plan was reviewed, and progress was reinforced. Functional analysis began with an overview of behavior chains and psychoeducation on different categories of triggers to drink. The therapist explained a drinking behavior chain as a learned sequence of events (see Figure 25.1). The therapist and couple made a list of Andrew’s specific environmental, interpersonal, cognitive, emotional, and physiological triggers: (1) particular co-workers asking him to go out after work, (2) get-togethers with Andrew’s family, (3) depression symptoms (feeling irritable or “useless”), and (4) working on house projects. Further information about drinking antecedents came from reviewing Andrew’s daily diary logs at the start of each session.

Therapy Sessions 3–7

By Session 3, Andrew had been abstinent for 5 days; however, he continued to report strong cravings. The therapist normalized this, explaining that most people continue to have cravings after they stop drinking. When the therapist asked what strategies Andrew had used to not drink, he described avoidance strategies such as staying busy and asking Erin to get all the alcohol out of the house. Erin’s mood had improved, which she attributed to Andrew’s abstinence. Sessions 3–7 focused on behavioral strategies to maintain abstinence and cope with cravings, and on initial couple-based interventions. Given that ambivalence about change is normal early in treatment for AUD, the therapist also addressed motivational enhancement with Andrew. Specifically, the therapist had Andrew complete a “decisional matrix” (Marlatt & Gordon, 1985; McCrady & Epstein, 2021) of positive and negative consequences of abstinence versus continued drinking.

In these sessions, Andrew and Erin also developed self-management plans to deal with spe-



TRIGGER	THOUGHTS & FEELINGS	BEHAVIOR	POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
Coworker asks me out to the sports bar after work last Thursday	Excitement. "It's been a long day at work." "I'll go for a little while, have a couple drinks."	Stay at bar longer than I had wanted. Drink 5 pints at bar. Drink whiskey when I get home.	Relaxed. Enjoy time with friends. Feel happy.	Drank more than intended. Missed Grant's game. Didn't see my family at all that day. Felt guilty next day.
Eating dinner at Mom and Dad's, brother pours and hands me a whiskey	"Why not?" "Everyone else drinks, it doesn't have to be such a big deal."	Drink glass of whiskey, then had three more and two beers.	Relaxed. Enjoying time with family. Tastes good.	Drank more than intended. Erin had to drive home. Kids saw me drunk. Started work week tired and irritable.
Working on bathroom renovation last weekend	"A few beers would make this more enjoyable." "It's fun anyway. I can do this. Maybe I'll drink later but I'm not going to now."	Buy some soda to drink instead. Listened to music while working. Grant ended up helping me out.	Felt proud about how much I got done. Still sober at dinnertime. Cravings went away quickly! Spent quality time with Grant.	Missed the taste of beer.

FIGURE 25.1. Functional analysis of Andrew's drinking.

cific triggers. For example, other people offering Andrew drinks—mostly coworkers or family members—was a common trigger. While drink refusal would become an important part of treatment, at this point, Andrew decided to cope with this trigger by spending more time with his immediate family and going out less with friends.

Relatedly, the therapist encouraged Andrew and Erin to develop a plan for coping with his family-related triggers. Andrew decided to tell his family that he had stopped drinking, and Erin agreed to help him stick to this plan at the next gathering. This was difficult given that almost everyone in Andrew's family drank heavily, especially his dad and three brothers. Andrew and Erin also agreed to limit the time they would spend at these gatherings, leaving right after dinner, until he felt fewer cravings and more confident and comfortable with not drinking.

During these early sessions, Andrew and Erin also worked with the therapist to increase the salience of negative consequences of drinking and positive consequences of abstinence. After he stopped drinking, between Sessions 3 and 6, Andrew mentioned some positive consequences of abstinence, primarily that he was less irritable with his kids. However, he also reported feeling as though he was "white knuckling it, taking it day by day." Notably, the daily logs were not showing any changes in his low mood. "I am happy that Erin is happy, but I'm still feeling pretty down." The small positive consequences he did endorse were highlighted by the therapist. The therapist also encouraged Andrew to introduce pleasurable activities to help bolster the positive consequences of being abstinent and to help alleviate depression. This included assigning Erin and Andrew the homework of doing at least two relaxing, enjoyable activities together during the week. They decided to ask Erin's mom to watch the kids to allow for a "date night." By Session 7, there was a noticeable improvement in Andrew's mood, and he expressed feeling more confident to not drink. The therapist noted that Andrew's continued abstinence was accompanied by improved mood and sleep, which he had not realized but was clear on his daily diary cards.

To make negative consequences of drinking more salient, Andrew carried an index card on which he had written the negative consequences of drinking on one side and positive consequences of not drinking on the other. He began reviewing the card each day after work. Andrew and Erin also agreed that he would tell Erin when he was having cravings to drink, and they practiced having an "urge discussion." He noted, "When I say it out loud to her, it helps make it less intense."

Erin had said many times in session that she proud was of him for not drinking, and Andrew said that this helped motivate him to keep going. Andrew began calling Erin every day after work. Erin expressed appreciation for these calls: "It's great to have him talking to me." Erin learned that when Andrew said, "I'm having a craving," it did *not* mean he was going to drink, and that the best way to help was to listen, empathize, and offer help.

Time also was spent exploring the spots in Andrew's functional analysis related to Erin to assess what role, if any, she played in his drinking. Erin identified several ways she had "protected" Andrew from the negative consequences of his drinking. One example was when Erin or her mom took on responsibilities such as attending the children's events, driving them around, or helping with homework, instead of asking Andrew to do so. "It's not even because I don't want to," Andrew explained. "I think Erin never transferred out of that single mom mindset after my deployment." Erin acknowledged this, but also pointed out that Andrew was often irritable with the kids because he either wanted to drink or was drinking. The therapist worked with the couple to decide when and where Andrew would take on responsibilities with the kids.

Therapy Sessions 8–11

By Session 8, Andrew had been abstinent for 6 weeks. He moved from daily, intense cravings in Week 3, to 2 days with low-intensity cravings in Week 7. At Session 9, however, he reported a slip at a family barbeque. Earlier that day, he had argued with his father, who had called to invite him to lunch at a brewery with his brothers. Andrew said "no" and was annoyed to have even been invited. That evening, Andrew was out on the porch when his brother suggested he try a new microbrew. He drank three beers and stopped when Erin came outside. Andrew was depressed at Session 9; he spoke negatively about himself and the slip, expressing hopelessness about his recovery. Time was spent completing a behavior chain of the slip, during which Andrew reported thoughts such as "Why can't I drink normally, like my brothers?"—thoughts that led to frustration, embarrassment, and hopelessness. Erin had been unaware of Andrew's argument with his father that day and did not know how upset Andrew was by dinnertime. They discussed the consequences of the slip and what he could have done differently. One conclusion they made was that poor communication, which had been discussed in Session 8, was one factor that contributed to his slip. Time during Sessions 9–11 was spent on improving communication; other topics covered were cognitive coping strategies for alcohol-related thoughts, drink refusal skills, and psychoeducation about the reciprocal links between depression and drinking.

Andrew and Erin had many strengths in their marriage. They had similar views of their roles within their family, and their parenting styles were complementary. However, there were a few relationship issues to address. Erin believed she and Andrew still were not talking as much as she would like, and Andrew felt that they did not spend enough time together. The therapist noted these issues as well. Andrew was less communicative than Erin in sessions, with the therapist using various approaches to encourage him to share his thoughts and feelings. Although he was not intentionally noncommunicative, the therapist noted that he often conveyed a cognitive schema that "it (referring to his own thoughts and emotions) doesn't matter." In response, Erin would become quiet herself, unintentionally reinforcing this pattern and his beliefs. This communication pattern was especially evident when discussing difficult topics.

The ideas of "leveling and editing" resonated with the couple (McCrady & Epstein, 2009b), especially the need for more leveling. They were assigned homework to designate a time every day to "check in" and discuss any issues. This was quite successful for them, and they practiced using positive communication skills learned during therapy. When Andrew brought up difficult topics, Erin used more adaptive response styles instead of withdrawing or reacting with worry. In response, Andrew began to open up more. Erin appreciated that they were talking more, and Andrew found that these daily conversations positively impacted his mood.

Given that other people were major triggers for Andrew's drinking, substantial time was spent role playing drink refusal skills. Using his slip as an example, Andrew practiced assertively saying "no" to his brothers and coworkers. Andrew realized that many of his relationships had been forged around drinking, which made it difficult to imagine socializing without drinking. Therefore, his drink refusal skills included generating ideas for alternative options to socialize.

Therapy Sessions 12–15

In the final sessions, the therapist and couple reviewed and continued to practice skills.

Andrew was becoming more confident in his ability to remain abstinent, and his depression had decreased substantially. At Session 12, his BDI-II score was 15, indicating mild depression. His sleep had also improved. He and Erin were settling into a new lifestyle in which they spent more time together and communicated more often. The last sessions focused on problem solving, establishing family meetings, and relapse prevention. They developed lists of "red flags" (warning signs) for relapse and a set of possible responses to each red flag. Andrew's list of red flags included (1) having trouble sleeping, (2) feeling depressed for more than a week, (3) "clamming up"—not talking to Erin about how he was doing, (4) stopping the new healthy, enjoyable activities he had started (hiking, exercising), and (5) withdrawing socially/isolating from family. His strategies for dealing with a drinking slip were to (1) tell Erin right away, (2) leave the drinking situation, (3) review his card with negative consequences of drinking and positives of not drinking, and (4) review the "relapse contract" (Marlatt & Gordon, 1985) that he and Erin wrote up. The terms of the contract were (1) Andrew will inform Erin of any drinking or strong urges to drink; (2) if Andrew drinks at all, he will do a behavior chain of the drinking situation with Erin to try to figure out what happened; he will also call his therapist to discuss it; and (3) Andrew and Erin will discuss the necessity of returning to treatment if Andrew drinks once a week (or more) for 2 weeks in a row, or if he has 2 weeks of frequent urges.

By the end of treatment, Andrew and Erin had noticed improvements in several areas of their lives, including abstinence from alcohol, decreased depression, improved sleep, and better communication. Also notable was the time Andrew was spending with Erin and the kids. "I hadn't realized how much time drinking was taking up in my life," he said. "Now I have time to do things that I actually enjoy, with the people I enjoy."

CONCLUDING COMMENTS

Treating AUD in a couple format is both challenging and rewarding. The therapist who uses ABCT must draw on a range of therapeutic skills to be effective. The therapist needs to establish multiple therapeutic alliances with the IP, SO, and the couple as a unit; teach both partners about the nature of AUD and the process of change; help the IP change their drinking and help the SO learn supportive behaviors while dealing with their own feelings and history with the drinking; and simultaneously help the couple to develop and enhance their relationship. These therapeutic tasks can blend smoothly as the therapist gains experience with ABCT, and tools such as the McCrady and Epstein therapist manual and workbook (2009a, 2009b) provide detailed guidance for the therapist who is learning the model.

ABCT is a powerful model for successful change, as the treatment blends a focus on individual coping skills with changing the system in which the IP's drinking is embedded. This combination of skills training and system change likely accounts for the positive drinking and relationship outcomes from ABCT. AUD is treatable, and the changes that follow from successful AUD treatment reverberate through the family and enhance the mental and physical health of the IP and their family. The challenges of treating persons with AUD and in using ABCT are well worth the results.

SUGGESTIONS FOR FURTHER STUDY

McCrady, B. S. (2000). *Couples therapy for addictions: A cognitive-behavioral approach.* San Francisco: Psychotherapy.net. Available at *www.psychotherapy.net/video/couples-therapy-addictions*.

McCrady, B. S., & Epstein, E. E. (2009a). *Overcoming alcohol problems: A couples-focused program*. New York: Oxford University Press.

McCrady, B. S., & Epstein, E. E. (2009b). *Overcoming alcohol problems: Workbook for couples*. New York: Oxford University Press.

McCrady, B. S., & Epstein, E. E. (2021). Alcohol use disorders. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (6th ed., pp. 555–611). New York: Guilford Press.

McCrady, B. S., Wilson, A., Muñoz, R., Fink, B., Fokas, K., & Borders, A. (2016). Alcohol-focused behavioral couple therapy. *Family Process, 55,* 443–459.

ACKNOWLEDGMENT

Preparation of this chapter was supported in part by the Department of Veterans Affairs, Veterans Health Administration (CSR&D Grant No. CX001951). The opinions expressed here are those of the authors and do not represent the official policy or position of the U.S. Department of Veterans Affairs or the U.S. government.

REFERENCES

Ahuja, A., Orford, J., & Copello, A. (2003). Understanding how families cope with alcohol problems in the UK West Midlands Sikh community. *Contemporary Drug Problems, 30,* 839–873.

Allen, M. S., & Walter, E. E. (2018). Health-related lifestyle factors and sexual dysfunction: A meta-analysis of population-based research. *Journal of Sexual Medicine, 15,* 458–475.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Beck, A., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory–II.* San Antonio, TX: Psychological Corporation.

Bouma, R., Halford, W. K., & Young, R. (2004). Evaluation of the Controlling Alcohol and Relationship Enhancement (CARE) program with hazardous drinkers. *Behaviour Change, 21,* 229–250.

Caetano, R., Schafer, J., & Cunradi, C. B. (2001). Alcohol-related intimate partner violence among white, black, and Hispanic couples in the United States. *Alcohol Research and Health, 25,* 58–65.

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2016). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence, 8,* 110–131.

Castro, F. G., Garvey, M., Kellison, J. G., & Marsiglia, F. F. (2013). Ethnic and cultural minority populations. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (2nd ed., pp. 758–787). New York: Oxford University Press.

Drapkin, M. L., McCrady, B. S., Swingle, J., Epstein, E. E., & Cook, S. M. (2005). Exploring bidirectional couple violence in a clinical sample of female alcoholics. *Journal of Studies on Alcohol, 66,* 213–219.

Epstein, E. E., McCrady, B. S., Cook, S., Morgan, T. J., Kugler, G., & Ziedonis, D. (2007). Couples treatment for drug-dependent males: Preliminary efficacy of a stand alone outpatient model. *Addictive Disorders and Their Treatment, 6,* 21–37.

First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2013, January). *Structured Clinical Interview for DSM-5 Disorders—Patient edition* (SCID-RV/P). New York: Columbia University.

Fokas, K., McCrady, B. S., & Houck, J. (2020). Inside Alcohol Behavioral Couple Therapy (ABCT): In-session speech trajectories and drinking outcomes. *Journal of Substance Abuse Treatment, 118,* Article 108122.

Green, K., Pugh, L., McCrady, B. S., & Epstein, E. E. (2008). Unique aspects of female primary-alcoholic relationships. *Addictive Disorders and Their Treatment, 7,* 169–176.

Hallgren, K. A., & McCrady, B. S. (2016). We-language and sustained reductions in drinking in couple-based treatment for alcohol use disorders. *Family Process, 55,* 62–78.

Hildebrandt, T., McCrady, B. S., Epstein, E. E., Cook, S., & Jensen, N. (2010). When should clinicians switch treatments?: An application of signal detection theory to two treatments for women with alcohol use disorders. *Behavior Research and Therapy, 48,* 524–530.

Holzhauer, C. G., Cucciare, M., & Epstein, E. E. (2020). Sex and gender effects in recovery for alcohol use disorder. *Alcohol Research: Current Reviews, 40*(3).

Holzhauer, C. G., Epstein, E. E., Cohn, A. M., McCrady, B. S., Graff, F. S., & Cook, S. (2017). Heterogeneity in pathways to abstinence among alcohol dependent women in treatment. *Journal of Substance Abuse Treatment, 75,* 1–9.

Kranitz, L. S., & Cooney, N. L. (2013). Treatment decision making and goal setting. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (2nd ed., pp. 352–376). New York: Oxford University Press.

Kuenzler, A., & Beutler, L. E. (2003). Couple alcohol treatment benefits patients' partners. *Journal of Clinical Psychology, 59,* 791–806.

Lammers, S. M. M., Schippers, G. M., & van der Staak, C. P. F. (1995). Submission and rebellion: Excessive drinking of women in problematic heterosexual partner relationships. *International Journal of the Addictions, 30,* 901–917.

Margolin, G., Talovic, S., & Weinstein, C. D. (1983). Areas of Change Questionnaire: A practical approach to marital assessment. *Journal of Consulting and Clinical Psychology, 51,* 920–931.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention.* New York: Guilford Press.

McCrady, B. S., & Epstein, E. E. (2009a). *Overcoming alcohol problems: A couples-focused program.* New York: Oxford University Press.

McCrady, B. S., & Epstein, E. E. (2009b). *Overcoming alcohol problems: Workbook for couples.* New York: Oxford University Press.

McCrady, B. S., & Epstein, E. E. (Eds.). (2013). *Addictions: A comprehensive guidebook* (2nd ed.). New York: Oxford University Press.

McCrady, B. S., & Epstein E. E. (2021). Alcohol use disorders. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (6th ed., pp. 555–611). New York: Guilford Press.

McCrady, B. S., Epstein, E. E., Cook, S., Jensen, N. K., & Hildebrandt, T. (2009). A randomized trial of individual and couple behavioral alcohol treatment for women. *Journal of Consulting and Clinical Psychology, 77,* 243–256.

McCrady, B. S., Epstein, E. E., Cook, S., Jensen, N. K., & Ladd, B. O. (2011). What do women want?: Alcohol treatment choices, treatment entry and retention. *Psychology of Addictive Behaviors, 25,* 521–529.

McCrady, B. S., & Flanagan, J. (2021). The role of the family in alcohol use disorder recovery. *Alcohol Research, 41.* [Epub ahead of print]

McCrady, B. S., Hayaki, J., Epstein, E. E., & Hirsch, L. S. (2002). Testing hypothesized predictors of change in conjoint behavioral alcoholism treatment for men. *Alcoholism: Clinical and Experimental Research, 26,* 463–470.

McCrady, B. S., Noel, N. E., Stout, R. L., Abrams, D. B., & Nelson, H. F. (1991). Effectiveness of three types of spouse-involved behavioral alcoholism treatment: Outcome 18 months after treatment. *British Journal of Addictions, 86*, 1415–1424.

McCrady, B. S., Tonigan, J. S., Ladd, B. O., Hallgren, K. A., Pearson, M. R., Owens, M. D., & Epstein, E. E. (2019). Alcohol Behavioral Couple Therapy: In-session behavior, active ingredients and mechanisms of behavior change. *Journal of Substance Abuse Treatment, 99,* 139–148.

McCrady, B. S., Wilson, A., Muñoz, R., Fink, B., Fokas, K., & Borders, A. (2016). Alcohol-focused behavioral couple therapy. *Family Process, 55,* 443–459.

McGue, M., & Irons, D. E. (2013). Etiology. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (2nd ed., pp. 36–72). New York: Oxford University Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change.* New York: Guilford Press.

Miller, W. R., Tonigan, J. S., & Longabaugh, R. (1995). *The Drinker Inventory of Consequences (DrInC)* (Project MATCH Monograph Series No. 4). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Muyingo, L., Smith, M. M., Sherry, S. B., McEachern, E., Leonard, K. E., & Stewart, S. H. (2020). Relationships on the rocks: A meta-analysis of romantic partner effects on alcohol use. *Psychology of Addictive Behaviors, 34,* 629–640.

National Institute on Alcohol Abuse and Alcoholism. (2020). *Alcohol facts and statistics: Alcohol use in the United States.* www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics.

O'Farrell, T. J., Choquette, K. A., & Cutter, H. S. (1998). Couples relapse prevention sessions after behavioral marital therapy for male alcoholics: Outcomes during the three years after starting treatment. *Journal of Studies on Alcohol*, *59*(4), 357–370.

O'Farrell, J. T., & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse.* New York: Guilford Press.

O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology, 72,* 202–217.

O'Farrell, T. J., Schumm, J. A., Murphy, M. M., & Muchowski, P. M. (2017). A randomized clinical trial of behavioral couples therapy versus individually-based treatment for drug-abusing women. *Journal of Consulting and Clinical Psychology, 85,* 309–322.

Paolino, T. J., Jr., & McCrady, B. S. (1977). *The alcoholic marriage: Alternative perspectives.* New York: Grune & Stratton.

Rosenthal, R. N. (2013). Treatment of persons with substance use disorder and co-occurring other mental disorders. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (2nd ed., pp. 659–707). New York: Oxford University Press.

Rotunda, R. J., West, L., & O'Farrell, T. J. (2004). Enabling behavior in a clinical sample of alcohol-dependent clients and their partners. *Journal of Substance Abuse Treatment, 26,* 269–276.

Satre, D. (2013). Treatment of older adults. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (2nd ed., pp. 742–757). New York: Oxford University Press.

Sobell, L. C., & Sobell, M. B. (2003). Alcohol consumption measures. In J. P. Allen & V. Wilson (Eds.), *Assessing alcohol problems* (2nd ed., pp. 75–99). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Spanier, G. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38,* 15–28.

Steinglass, P., Bennett, L. A., Wolin, S. J., & Reiss, D. (1987). *The alcoholic family.* New York: Basic Books.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283–316.

Sullivan, E. V., & Pfefferbaum, A. (2019). Brain–behavior relations and effects of aging and common comorbidities in alcohol use disorder: A review. *Neuropsychology, 33,* 760–780.

Vedel, E., Emmelkamp, P. M. G., & Schippers, G. M. (2008). Individual cognitive-behavioral therapy and behavioral couples therapy in alcohol use disorder: A comparative evaluation in community-based addiction treatment centers. *Psychotherapy and Psychosomatics, 77,* 280–288.

Wagner, E. F., & Baldwin, J. A. (2020). Recovery in special emphasis populations. *Alcohol Research, 40,* Article 5.

Walitzer, K. S., & Derman, K. H. (2004). Alcohol-focused spouse involvement and behavioral couples therapy: Evaluation of enhancements to drinking reduction treatment for male problem drinkers. *Journal of Consulting and Clinical Psychology, 72,* 944–955.

CHAPTER 26

Couple Therapy for Depression or Anxiety

Mark A. Whisman, Steven R. H. Beach, and Joanne Davila

Based on 2015 estimates, 4.4% of the global population (~322 million people) suffer from a depressive disorder, and 3.6% (~264 million people) suffer from an anxiety disorder; globally, depressive disorders are the single largest contributor to nonfatal health loss, and anxiety disorders are the sixth largest contributor (World Health Organization, 2017). Therefore, the development and evaluation of treatments for depression or anxiety have important public health implications. Because the relationship that a person forms with their romantic partner is often among the most, if not the most, important and long-standing interpersonal relationship formed during adulthood, an individual's mental health is likely to influence, and be influenced by, intimate relationship functioning, and improving relationship functioning is likely to better an individual's mental health.

In this chapter, we review cognitive-behavioral couple therapies as treatments of depression or anxiety. Depression and anxiety (along with couple relationship difficulties) are commonly cited presenting problems reported by practicing couple and family therapists (Northey, 2002). We discuss anxiety disorders in general, as well as focus on generalized anxiety disorder (GAD), social anxiety disorder (SAD), and obsessive–compulsive disorder (OCD). (See also Chapter 24 on posttraumatic stress disorder, in this volume, by Monson & Fredman.)

Depression and anxiety disorders tend to co-occur with one another. For example, statistically significant correlations exist for the association between 12-month prevalence of major depressive episode (MDE) and GAD, social phobia, and OCD (Kessler, Chiu, Demler, & Walters, 2005). In addition, the presence of depressive (or anxiety) disorders at one point in time is associated with elevated risk of anxiety (or depressive) disorders at a later time. For example, in an analysis of representative community samples from 27 countries, people who met criteria for MDE or GAD were at elevated risk for subsequently developing the other disorder: For people with MDE, the absolute risk for developing GAD for 5, 10, and 15 years later were 9, 11, and 14%, respectively, whereas for people with GAD, the absolute risk for developing MDE over the same time periods were 28, 38, and 47%, respectively (McGrath et al., 2020). In other words, approximately 14% of people with MDE will develop GAD over the next 15 years, whereas approximately 47% of people with GAD will develop an MDE over the next 15 years.

Because of the high comorbidity between depression and anxiety, many intimate relationship characteristics associated with depression also are likely to be associated with anxiety. For example, the associations between relationship quality and specific internalizing disorders such as major depression and anxiety disorders may be due, at least in part, to the common or shared features among these disorders (South, Krueger, & Iacono, 2011). As such, although we discuss depression and anxiety separately throughout this chapter, and specify the disorders that have been associated with specific theories, empirical findings, and interventions, much of the content discussed for one internalizing disorder (e.g., major depression) may apply to other internalizing disorders (e.g., GAD), although research is needed to evaluate this perspective.

BACKGROUND

Couple Therapy for Depression

Couple therapy for depression (Beach, Sandeen, & O'Leary, 1990) began as an adjunctive treatment for depressed individuals in committed romantic relationships. Initially, the conceptual foundation was provided by the empirical literature on stress and social support in depression, which suggested that addressing social difficulties in depression would be palliative for most depressed individuals and might in some cases be curative. Beach and colleagues adopted the position that couple therapy for depression is probably best limited to persons with significant relationship disputes, particularly those related to the onset or exacerbation of the depressive episode. However, because limited positive interactions with close others appear to constitute a general problem in depression, and have been shown to predict within-person changes in symptom levels (Barton et al., 2022), there may be utility in providing couple interventions, even with depressed persons who do not report relationship discord.

Couple therapy for depression is a variant of cognitive-behavioral couple therapy (see also Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), designed to treat depression and later published in manual form (Beach et al., 1990). It focuses on the elimination of stressful and distressing transactions, and the enhancement of social support provision within the relationship; in particular, its goal is to enhance the view of the partner as a reliable person who can be counted on to listen to and work with the depressed individual. It is based on the premise that a decrease in level of depression will occur primarily as a function of improvement in relationship quality.

Couple Therapy for Anxiety

Theorists have long suggested that aspects of the couple system can maintain and exacerbate anxiety, and that couple-based interventions may be effective in treating anxiety (Byrne, Carr, & Clark, 2004). Partner-assisted exposure therapy for panic disorder was the earliest cognitive-behavioral couple therapy to be advanced. In this approach, one partner supports and encourages the other to confront or engage in the anxiety-provoking situation and to resist avoidance, which works to reinforce the development of anxiety management skills (Byrne et al., 2004). Similarly, partner-assisted treatment for OCD focuses on teaching partners how to assist with exposure exercises, as well as on enhancing communication and improving decision making for planning and practicing exposure (Abramowitz & Baucom, 2020; Baucom, Fischer, Corrie, Worrell, & Boeding, 2020). For the treatment of GAD, Benson, Doss, and Christensen (2018) adapted an online relationship program (OurRelationship.com) to include mindfulness exercises, acceptance of internal experiences (e.g., anxiety), engagement in value-driven behavior, and addressing relationship patterns related to GAD. Chambless (2012) developed family-focused therapy for anxiety disorders (FFT-AD), designed as an adjunct to individual cognitive-behavioral therapy for anxiety disorders. It is predicated on the idea that negative relationship processes, such as hostility, criticism, and emotional overinvolvement, can hinder treatment. Although developed as a family-focused treatment, FFT-AD readily generalizes to couple therapy for anxiety. The treatment shares much in common with couple therapy for depression, including communication and problem-solving training, as well as psychoeducation about anxiety disorders and the stress–vulnerability model of anxiety.

CORE UNDERSTANDINGS ABOUT THESE POPULATIONS

Much of the research on relationship functioning and depression and anxiety has focused on relationship quality, with poor relationship quality (i.e., relationship discord) viewed as a general stressor that can increase risk for psychopathology. Relationship discord has demonstrated cross-sectional and longitudinal associations with depressive disorders and symptoms. For example, research on representative community samples indicates that individuals with a current depressive disorder report higher relationship discord relative to those without a depressive disorder (Whisman, 2007). Longitudinal research indicates that relationship discord predicts increases in depressive symptoms (Beach, Katz, Kim, & Brody, 2003; Whisman & Uebelacker, 2009), and that relationship discord and depressive symptoms covary over time within individuals—that is, when a person's relationship discord is higher than usual, their depressive symptoms also tend to be higher (Davila, Karney, Hall, & Bradbury, 2003; Whisman, Davila, & Goodman, 2011). Furthermore, relationship discord predicts the incidence (i.e., onset) of depressive disorders (Overbeek et al., 2006; Whisman & Bruce, 1999). The cross-sectional and longitudinal association between relationship discord and depression has been observed in traditionally understudied populations (including racial, ethnic, and sexual minority groups) and countries throughout the world (for a review, see Whisman, Sbarra, & Beach, 2021).

The couple discord model of depression has continued to evolve since its initial presentation in 1990. In previous presentations (Beach & Whisman, 2012), we have adopted a variant of the "stress generation" framework (Hammen, 1991). Our expanded model posits that depressed individuals generate stress in their interpersonal environments, and that this interpersonal stress can in turn exacerbate or maintain depression. This is consistent with data showing that depressed individuals tend to seek negative feedback, to engage in excessive reassurance seeking, to avoid conflict and withdraw, and to elicit changes in their partners' view of them (Joiner, 2000). As such, we consider relationship discord and depression to be components of a larger vicious cycle that creates a self-sustaining loop, consistent with what has been observed in longitudinal studies (Davila, Bradbury, Cohan, & Tochluk, 1997).

Similar to findings for depression, research involving representative community samples has shown that relationship discord is associated in cross-sectional studies with anxiety symptoms (Leach, Butterworth, Olesen, & Mackinnon, 2013), and in longitudinal studies with increases in symptoms of GAD (Whisman, Robustelli, & Labrecque, 2018). Furthermore, research based on representative samples indicates that relationship discord is associated with the prevalence of anxiety disorders in general and with GAD and SAD specifically (Whisman, 2007), and with the incidence of anxiety disorders in general and social phobia in particular (Overbeek et al., 2006). Finally, multiwave within-subject analysis has shown that when a person's relationship discord is higher than usual, their anxiety symptoms also tend to be higher (Whisman et al., 2011).

Extreme Stress

Stress is a well-known causal factor in the development of depression and anxiety disorders. Intimate partner violence (IPV) is associated with both depression and anxiety disorders (Spencer et al., 2019). In addition, severe relationship stressors, such as discovery of a partner affair or having a partner threaten to end the relationship (Cano & O'Leary, 2000), are examples of stressful relationship events that are associated with depression and may have an impact on depression over and above their shared association with relationship discord. In addition, severe spousal denigration, criticism and blame, and severe disruption of relationship routines, including failure to share household chores and avoidance of physical contact, are commonly observed in couples with a depressed or anxious partner.

High Levels of Negative Behavior

In addition to well-established behavioral and cognitive symptoms of relationship discord, such as endorsing more negative relationship events and greater reactivity to a partner's negative behaviors, couples with a depressed partner may display unique levels of behavioral negativity. A depressed person may express negativity about not only themselves (i.e., negative self-statements), but also about their partner and their future. Depressive behaviors, which include sighing, lack of eye contact, long latencies between speech utterances, and other poor social skills characteristic of depression (Segrin, 2000), may change the tenor of conversations couples have and decrease the efficiency of their problem solving. Similarly, anxiety disorders are associated with significant interpersonal impairment of a nature that can impact romantic relationships, including attachment insecurity (Mickelson, Kessler, & Shaver, 1997) and numerous interpersonal skills deficits (Alden & Taylor, 2004; Przeworski et al., 2011).

High Expressed Emotion and Perceived Criticism

One interpersonal process that has been studied in the context of couples and families is "expressed emotion" (EE), which refers to the extent to which a person expresses criticism, hostility, or emotional overinvolvement regarding a family member with a psychiatric disorder to a researcher during a private interview. A meta-analysis of prospective studies of the association between EE and relapse in people with mood disorders found mean effect sizes (*r*) ranging from 0.39 to 0.45 (Butzlaff & Hooley, 1998), indicating medium to large associations.

In addition to measuring actual criticism expressed by family members toward a depressed person, researchers have also studied depressed individuals' subjective reports of how critical they believe their partners or family members are of them—that is, "perceived criticism" (Hooley & Teasdale, 1989). A literature review indicated that higher perceived criticism prospectively predicted worsening depression or negative affect; this association was found in clinical and nonclinical samples, and with both depressive relapse and change in depressive symptoms or negative affect (Renshaw, 2008). Similarly, perceived criticism has been associated with anxiety disorders. For example, one study indicated that relative to control couples free of psychopathology, a clinical sample of individuals with SAD and individuals with other anxiety disorders reported higher levels of perceived criticism (Porter, Chambless, Keefe, Allred, & Brier, 2019).

Accommodation and Reassurance Seeking

One behavior observed in partners of individuals with anxiety disorders is "accommodation," which refers to partners assisting anxious individuals in avoiding or escaping from anxiety-provoking situations and responsibilities (Abramowitz & Baucom, 2020; Baucom et al., 2020; Chambless, 2012). Accommodation is generally driven by the desire to reduce the anxious individual's distress, with partners generally believing they are being helpful. Although accommodation may reduce anxiety in the short term, because it also reduces the anxious individual's exposure to anxiety-provoking situations, it inadvertently maintains their fear and anxiety in the long-term through negative reinforcement. In OCD, accommodation may involve the partner engaging in rituals that parallel those of the person with OCD, such as washing and cleaning to help the person with OCD to avoid feared contaminants, or avoiding situations or settings that trigger OCD obsessions about unwanted topics (e.g., sex) (Abramowitz & Baucom, 2020). Higher levels of partner accommodation are associated with not only more severe OCD symptoms but also poorer relationship functioning (Boeding et al., 2013). In SAD, accommodation may involve speaking for the anxious partner or helping them avoid social interaction that may provoke anxiety (Abramowitz & Baucom, 2020). In GAD, accommodation often takes the form of responding to repetitive, excessive reassurance seeking (ERS), in which the anxious individual repeatedly seeks reassurance from the partner regarding worry (i.e., threat) domains, such as the security of their relationship and that nothing dangerous or upsetting has or will occur (Chambless, 2012). Consistent with this perspective, ERS is positively associated with anxiety symptoms in general and GAD and SAD symptoms in treatment-seeking individuals with anxiety disorders (Rector et al., 2019). ERS is also associated with depression: A meta-analysis of 38 studies yielded an aggregate effect size (*r*) of 0.32, indicating a medium association between ERS and depression (Starr & Davila, 2008).

Deficits in Problem Solving and Communication

Difficulty in resolving relationship problems is greater for couples in which one partner is depressed or anxious than for couples in which relationship discord is uncomplicated by depression or anxiety. A systematic review of the literature on the relationship interactions of depressed individuals concluded that such interactions are "characterized by a higher frequency of negative communication behaviors (e.g., blame, withdrawal, verbal aggression) and a lower frequency of positive communication behaviors (e.g., self-disclosure, problem-solving behaviors, smiling, eye contact)" (Rehman, Gollan, & Mortimer, 2008, p. 182). There has been limited research examining interactions in couples in which one partner has anxiety. In a study involving U.S. service members and their at-home partners, people's reports of the valence of their communication during deployment predicted their own and their partner's generalized anxiety in the 8 months following homecoming (Knobloch, Knobloch-Fedders, & Yorgason, 2018).

Loss of Social Support and Low Couple Cohesion and Intimacy

Loss of critical elements of interpersonal support and low levels of cohesion and intimacy may result in greater risk for the development of depression or anxiety. Some of the supportive processes that are diminished when partners experience depression or anxiety in the context of relationship discord include (1) couple cohesion and shared pleasant activities; (2) acceptance of emotional expression and disclosure of personal feelings; (3) actual and perceived coping assistance in dealing with environmental and relationship stressors; (4) self-esteem support and noncritical feedback; (5) perceived partner dependability, availability, and commitment; and (6) intimacy and confiding in the partner. Lower levels of these behaviors may lead both partners to feel isolated and distant from one another.

THE PRACTICE OF COUPLE THERAPY FOR DEPRESSION OR ANXIETY

The Structure of the Therapy Process

Couple therapy for depression or anxiety is usually time-limited (typically 20 or fewer sessions), with sessions occurring weekly. Sessions typically involve (1) setting an agenda for the session, in collaboration with the couple; (2) reviewing the homework that the couple has done during the week; (3) addressing a problem, learning new skills, or practicing new ways for the partners to relate to one another; (4) deciding on a new homework assignment; and (5) summarizing what was covered in the session and eliciting feedback about the session.

Therapists need to structure sessions in a way that allows both partners to feel safe as they discuss relationship problems while working toward specific goals. Partners should know that the therapy session is not a time in which they can attack or be attacked. Creating a safe environment may include ground rules or guidelines that help partners to communicate in adaptive ways in session and plan for the prevention of destructive interactions outside of session. Partners' level of discord, their desired goals, and the level of structure that will facilitate progress toward these goals influence the degree of structure that is provided.

Homework is an important component of treatment because much of the work of couple therapy takes place between sessions. Selecting appropriate homework assignments, explaining them, and evaluating the degree of success with the previous week's assignment are integral components of each session. When introducing the concept of homework, the therapist emphasizes the individual responsibility of each partner to complete their part of the assignment.

The Role of the Therapist

Couple therapists are responsible for collaborating with the couple to plan treatment, set goals, and structure therapy sessions. The therapist creates a tentative agenda for each treatment session, begins each session by reviewing the proposed agenda with the couple, and requests feedback from the couple about the agenda. Therapists use time wisely by pacing therapy content within and across sessions.

Couple therapists strive to strike a balance between structuring treatment and providing flexibility. Structure can be particularly important for couples with a depressed or anxious partner because it can help alleviate helplessness or hopelessness and instill confidence in the therapist's abilities. However, it is also important that therapists are flexible enough to accommodate each partner's desires and goals, to treat each couple most effectively. Furthermore, depressed or anxious partners may be reluctant to mention problems that need to be addressed if the therapist does not provide an opportunity to add items to the agenda.

Couple therapists strive to adapt the therapeutic model skillfully to make it relevant for each couple. For example, therapists are responsible for choosing homework assignments that fulfill the goals of the model and are meaningful for each couple. Thus, specific details of homework assignments cannot be decided in advance, but rather emerge from the specific problems and strengths of the couple.

Assessment and Treatment Planning

Before beginning a course of treatment, the therapist needs to define the parameters of the presenting problem and establish goals for treatment. We recommend assessing the severity of relationship discord, evaluating the presence and severity of depression or anxiety, assessing suicide risk, and chronologically linking relationship discord with depression or anxiety. We also recommend ongoing (e.g., weekly) assessment throughout treatment to monitor changes in outcomes, enhance clinical decision making, and provide feedback to couples regarding treatment progress.

Assessing Relationship Functioning

A thorough assessment of a couple's relationship functioning is important in the initial stages of treatment. The initial assessment includes an interview of the couple, during which the therapist asks each partner for their perceptions of the ongoing problems in the relationship, the frequency and intensity of conflicts in their relationship, the common sources of conflicts, and the ways they typically deal with conflicts. Other common areas for assessment include partners' beliefs and thoughts about each other and about their relationship, and the extent to which, and the circumstances in which, they experience positive and negative feelings about each other and their relationship. Finally, the therapist asks partners about their goals for therapy, focusing on specific examples of how they would know that each goal has been reached. The interview usually ends with collection of a developmental history of the relationship, discussing the past and present strengths of the relationship, and briefly reviewing the efficacy of couple therapy for depression or anxiety. Partners can also be asked to complete one or more self-report questionnaires to provide additional information on the relationship, including their level of relationship quality; brief self-report measures of relationship quality can also be used for ongoing assessment. (See also Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin.)

Evaluating the Presence and Severity of Depression or Anxiety

In addition to assessing relationship functioning, it is important to assess for the presence and severity of depression or anxiety. Assessment of depression typically includes an interview and completion of one or more self-report measures of depressive symptoms (for a review, see Joiner, Walker, Pettit, Perez, & Cukrowicz, 2005). In interviewing a person about their depression, the clinician should obtain a complete history, including information about the current episode, past episodes, medical history, and family history. There are several brief self-report measures of depression that can be used for ongoing assessment, including, for example, the nine-item Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002; *www.phqscreeners.com*).

Similar to those working with depressed individuals, couple therapists working with people with anxiety disorders assess for these disorders using interview and self-report measures (for a review, see Antony & Rowa, 2005). In addition, it is important to carefully assess the extent to which accommodation by the partner is occurring, and its impact on the anxious partner and the relationship. Abramowitz and Baucom (2020) provide a helpful set of questions that clinicians can ask to assess for accommodation, and a review of measures to assess key relational problems. Finally, the seven-item Generalized Anxiety Disorder scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006; *www.phqscreeners.com*), the 12-item Brief Fear of Negative Evaluation Scale (Leary, 1983), and the 20-item Dimensional Obsessive–Compulsive Scale (Abramowitz et al., 2010) are recommended for ongoing assessment of GAD, SAD, and OCD, respectively.

Assessing Suicide Risk

Suicidal thoughts or thoughts of dying are common among depressed individuals seeking couple therapy and should not be considered a reason to delay or defer treatment. When present, however, such ideation should be thoroughly assessed, and suicidal potential should be examined. Self-report measures can be used regularly to assess the various facets of suicidal behavior (Osman et al., 2001). We suggest that although the presence of thoughts about suicide need not be a barrier to couple therapy for depression or anxiety, active suicidal intent involving self-harm, a suicide plan, or expressions of intent to commit suicide should be considered grounds for referral to individual treatment. In such cases it may be possible, and desirable, to make it clear that the therapist will offer couple therapy once doing so has been deemed safe and appropriate by the individual therapist. Because of the potential to disrupt the dual alliance with both partners, typically it would be considered inappropriate for the couple therapist to handle individual treatment of the suicidal problem, then resume couple therapy, or to provide both concurrently.

Linking Relationship Discord with Depression or Anxiety Chronologically

The co-occurrence of relationship discord and depression or anxiety can interact in ways that make it difficult to establish a complete picture of the sequence of their occurrence. Therapists can address this by examining the ways relationship discord and depression or anxiety symptoms have developed over time for a specific couple. Evidence of sequential etiology may influence a clinician's treatment plan in deciding between individual therapy and couple therapy. For example, individual therapy may not be as effective as couple therapy for partners who see relationship problems as strongly influencing their depression or who view relationship problems as preceding their depression (O'Leary, Riso, & Beach, 1990).

Decision Rules for Selecting among Interventions

Assessment can also be used to provide information for deciding whether to use couple therapy or to refer a depressed or anxious person for individual treatment. For depression, typically we make this decision by gauging the salience of the relationship discord relative to other areas of difficulty and stress. Sources of decision-making guidance for couples with a depressed partner are self-report and interview-based screening tools that characterize for a given couple whether they score above threshold levels with respect to relationship discord based on taxometric analyses, with those above the cutoff point being classified as "discordant" (Whisman, Snyder, & Beach, 2009). Because loss of positive interactions is common in depression, however, approaches focused on the enhancement of support may also provide a useful approach for depressed individuals who do not see their relationships as discordant (Bodenmann et al., 2008; Cohen, O'Leary, & Foran, 2010).

Goal Setting

The goals of couple therapy for depression are to reduce both depression and relationship discord by addressing their recursive influences (Beach et al., 1990). Similarly, the goals of couple-based interventions for anxiety disorders are to reduce emotional overinvolvement, perceived criticism, and excessive accommodation, and to encourage the partner's positive support for change (Chambless, 2012). In partner-assisted treatment for OCD, the goals are to (1) teach partners how to assist with exposure exercises by making sure they implement them correctly and by providing emotional support while the person practices exposure; (2) improve communication skills to enhance sharing of thoughts and feelings during exposure and decision making for planning and practicing exposure; and (3) reduce accommodation (Abramowitz & Baucom, 2020; Baucom et al., 2020).

To accomplish the goals for couple interventions for depression or anxiety in a time-limited manner, couple concerns are carefully assessed and prioritized. The therapist works collaboratively with the couple in establishing therapy goals and in setting an agenda for each session. For example, in the initial assessment session, the therapist works with partners in specifying their individualized goals for therapy. In helping partners define their goals, the therapist seeks to help them describe these goals in specific, behavioral terms (e.g., translating a general goal of "get along better" into a specific goal of "reduce the frequency of arguments involving name-calling").

Getting a couple to work toward common goals can be a difficult task. The therapist usually addresses this by increasing the couple's expectations for positive change in the relationship. Helping couples to define their problems and goals in a specific manner is one method to induce an expectation for change. Another way therapists can influence the perception of change is by helping couples monitor how far they have progressed since beginning therapy and pointing out positive changes that have taken place. Therapists can also provide couples with information on the efficacy of the approach, emphasizing that relationship discord and depression or anxiety decrease in a relatively brief time frame for many couples.

Process and Technical Aspects of Couple Therapy for Depression

Couple therapy for depression generally follows three stages (Beach et al., 1990). In the following material, we focus primarily on the initial stage of couple therapy for depression. Our clinical experience suggests that the initial stage of therapy is crucial because a couple with a depressed partner is likely to become demoralized and to give up if the partners do not see concrete evidence of progress in the first several sessions. Likewise, couples with a depressed partner may respond more positively than other discordant couples to high levels of session structure and clear homework assignments that instigate change. Once positive momentum has been established, it is possible to shift the focus to other aspects of the relationship, such as communication and problem-solving training. However, if a focus on problems in the relationship comes too early in therapy, there is greater potential for the couple in general, and the depressed partner in particular, to feel overwhelmed and hopeless.

First Stage of Therapy: Increasing Positive Behavior

Initial sessions focus on increasing relationship cohesion and self-esteem support, and reducing severe, recurrent relationship stressors. Unlike later phases of therapy, which require a greater level of tailoring to the needs of a particular couple, approaches in the initial phase of therapy are useful for most depressed couples and resonate well with the goals they bring to therapy. These approaches are helpful in elevating mood in the depressed partner, instilling a sense that change is possible for both partners, and preparing for the more difficult tasks involved in restructuring the relationship.

INCREASING RELATIONSHIP COHESION

One way to increase relationship cohesion is by encouraging the partners to engage in "caring gestures," which are behaviors performed with the goal of communicating love and caring. (See also Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom et al.) We focus here on three aspects of caring gestures that have been found to be helpful for depressed couples.

First, caring gestures should be performed frequently, preferably daily. Depressed persons tend to underestimate the frequency of positive events and have difficulty recalling positive things that have happened to them. This tendency is partially addressed by encouraging frequent events. Second, each person is responsible for performing caring gestures independently of the other partner's success in performing gestures. The independence of the caring-gestures assignment is established to preclude disruption of the assignment by either the perception or the reality of one partner getting off to a slow start. Third, therapists emphasize the importance of expressing appreciation to the partner for the caring behaviors they engage in; such reinforcement increases the likelihood that caring gestures will be repeated in the future.

Increasing "companionship activities," such as pleasant shared activities involving dating, recreational activities, and activities with other couples can also increase dyadic cohesion. Although sexual interactions can be shared positive events, it is important that therapists carefully assess the status of sex in a couple's relationship before including sensual and sexual behaviors as part of caring gestures or companionship activities. Because depressed individuals often experience sexual problems and loss of libido, it is possible that attempts at sexual interactions may not be positive experiences for one or both partners. If sexual interactions constitute a significant problem, sex therapy and other techniques may be implemented at a later stage in therapy. (See also Chapter 19 on sexuality, in this volume, by Hall & Watter.)

Depressed individuals can also be encouraged to increase the frequency of individual positive activities. When partners expect all their satisfaction to derive from activities involving each other, it can be particularly stressful to the relationship. This can serve as a barrier to couple cohesion because the nondepressed partner may withdraw due to the pressure of feeling solely responsible for the depressed partner's satisfaction. Thus, depressed partners are encouraged to actively pursue positive individual activities, while concurrently engaging in increased joint activities; in particular, they are encouraged to increase the frequency of activities that bring them a sense of pleasure or mastery, as in individual cognitive and behavioral therapies for depression. Furthermore, partners of depressed individuals can be instructed on how to encourage and reinforce completion of these individual positive activities.

INCREASING SELF-ESTEEM SUPPORT

A second aspect of the relationship that is targeted early in therapy is self-esteem support. Positive communication in which one partner expresses appreciation of the positive qualities or behaviors of the other is one major component of self-esteem support. As with caring gestures, positive communication is encouraged as a unilateral behavior, independent of partners' perceived reciprocity or behavior change.

The concept of self-esteem support is usually presented as "expressing what you normally take for granted." Hence, the goal is for individuals to verbalize thanks for the things their partners do for them, to acknowledge desired change in their partners, to give compliments, and to express positive beliefs and feelings about their partners. If couples are reluctant to participate, therapists can explain that being able to express positive feelings, compliments, and appreciation in a sincere and honest manner is important in keeping the relationship on the best course and providing a more accurate view of the partners and their relationship. Therapists can model positive communication through role plays and having partners practice with each other in session.

REDUCING OR ELIMINATING MAJOR STRESSORS

Although the goal is to increase positive events early in therapy, this strategy may not work for all couples. This may especially be the case if a couple is dealing with a large, overwhelming concern that makes it difficult to focus on increasing positive events. The therapist initially encourages the couple to work on increasing positive interactions before addressing larger issues in therapy. If this attempt fails, therapists proceed with helping partners address major concerns with the goal of temporary resolution. This is a necessary first step in the process of healing the relationship because the damage inflicted by some negative patterns can serve as a barrier to positive change in the relationship. Thus, a relatively low number of very negative interactions may eliminate the effects of a greater number of positive interactions. In such situations, the therapist does not attempt to teach any skills-building interventions, such as communication or problem-solving skills, in a formalized manner. Instead, the therapist makes the couple aware that the issue will probably need to be revisited later in therapy, when skills are taught and applied to the problem situation. The more immediate goal is to reduce major, idiosyncratic stressors that hinder progress.

Some negative patterns may be particularly predictive of depression and may exert effects beyond their impact on relationship quality. More specifically, partner criticism (Butzlaff & Hooley, 1998), perceived criticism (Renshaw, 2008), IPV (Spencer et al., 2019), and relationship events involving humiliation or devaluation (e.g., infidelity, threats of separation; Cano & O'Leary, 2000), have received attention as potentially potent precursors of depression and, when present, may need to be a focus of direct attention early in therapy. (See also Chapter 17 on partner aggression by Epstein, LaTaillade, & Werlinich, and Chapter 18 on infidelity by Gordon, Mitchell, Baucom, & Snyder, both in this volume.) For some couples, it will be possible to eliminate relationship-threatening behaviors in the short run through the use of pretherapy contracts in which both partners indicate that they will refrain from all such behaviors. For severely discordant couples, it may be necessary to alter the course of therapy by using structured individual interventions to increase one or both partner's self-control of disruptive behavior before a dyadic focus can be useful. We do not recommend this in the typical case, but if severe negative interactions persist after the first two to three sessions, it may be considered.

Accordingly, although the early focus of therapy is positive, some negative partner behaviors may require direct attention relatively early in therapy. This can often be accomplished through therapist feedback, by way of therapy contracts at the beginning of therapy, or in the context of communication training as described below.

Blaming or devaluing a partner through excessive criticism is seen as a major and chronic stressor in relationships. To avoid the detrimental effects of partners' name-calling and put-downs, it is often helpful for therapists to give couples explicit feedback regarding the dangers of denigrating, criticizing, and blaming comments. Therapist may also help nondepressed partners reattribute the cause of problems from internal, stable, blameworthy attributes of the depressed partner (e.g., something negative about their personality) to situationally determined, changeable, nonblameworthy factors (e.g., external stressors); doing so may promote more positive affect and a willingness to let go of the blame and denigration. Alternatively, therapists can encourage partners to explore the meanings attributed to certain behaviors. Once partners recognize that not every negative interaction is necessarily the result of negative intent, negative motivation, or selfishness, feelings of anger and rejection that accompany original misunderstandings are likely to be diminished.

Another method of reducing blame and criticism that is especially appropriate for couples with a depressed member is to discuss the nature of depression through psychoeducation. It is likely that some couples' primary relationship complaints may be related to symptoms of depression, such as lethargy, lack of concentration, sleep disturbance, self-focus, irritability, and loss of sexual interest. These symptoms can easily become the focus of conflict, which can be reduced by informing couples that behaviors associated with these symptoms will probably improve as the depression lifts. When partners better understand each other's behavior, it often becomes possible for them to change maladaptive patterns of criticism, blame, and denigration.

For many couples with a depressed partner, occasional thoughts of separation or divorce are natural. However, therapists remind partners of the evidence that they care about each other and are invested in each other's lives, and ask them to consider that threats to leave the relationship usually reflect only temporary feelings. Partners are encouraged not to verbalize thoughts of leaving because these thoughts occur in an inconsistent, vacillating pattern and do not represent a final decision, and because such verbalizations can be harmful to the relationship.

Second Stage of Therapy: Communication and Problem-Solving Training

The second phase of therapy generally focuses on communication and problem-solving training, which couples practice in session and at home.

Couples are first taught receptive, "listener" skills (e.g., making eye contact, nodding, verbally reflecting key points) and expressive, "speaker" skills (e.g., sharing thoughts and feelings, use of "I" statements, speaking in paragraphs). The goals of "sharing thoughts and feelings" conversations are to build intimacy and closeness. Couples are then taught steps involved in effective problem solving (e.g., problem definition, generating alternative solutions, evaluating and selecting solutions, implementing solutions). The goals of "problem-solving" conversations are to resolve conflict and solve problems, including conflicts and problems that are ongoing and those that may arise in the future. Learning constructive problem-solving skills may be particularly important for depressed individuals to cope more effectively with relationship conflict. The label "problem-solving" discussions has been expanded to include "decision-making" discussions because not all situations are "problems" to be solved but rather may involve difficult or complicated decisions to reach. (See also Chapter 3, "Cognitive-Behavioral Couple Therapy," in this volume, by Baucom et al.)

Bodenmann and colleagues (2008) suggested an alternative but conceptually consistent approach to restructuring relationships. The approach focuses on training partners to work together to process stressful events more effectively. Training partners to provide effective social support can complement or potentially supplement the focus on conflict management and problem solving that characterizes the middle phase of couple therapy for depression. In addition, given that the loss of positive interactions is common in depression, focusing on the enhancement of social support may be universally applicable to couples with a depressed partner; it need not be restricted only to those couples in discordant relationships.

Third Stage of Therapy: Maintenance and Generalization

The final phase of therapy focuses primarily on maintenance of change. During the last few sessions of therapy, we encourage couples to write out what they have learned in therapy and keep these written notes in a secure place to review as necessary. We also encourage couples to consider difficult or challenging times ahead (i.e., high-risk situations) and to problem-solve how they intend to deal with upcoming challenges and stressors. We generally recommend that therapists fade the frequency of sessions in the final stage of therapy, meeting every other week, then monthly. This allows couples time to practice the skills they learned in therapy, while still being able to seek therapists' help and support should they encounter problems. We also generally recommend booster maintenance sessions at longer-term follow-up (e.g., every 6 months for the first year, then yearly thereafter) to remind couples of the things they learned in therapy, assess changes that have occurred, and continue the process of relapse prevention. The key goals in the final phase of therapy include focusing on generalization, fading out the role of the therapist, and gradually narrowing the scope of therapy, so that new material is generally not presented. Problem solving is viewed as one primary method of relapse prevention, and couples are encouraged to tackle new issues on their own, using the problem-solving strategies learned in therapy.

Process and Technical Aspects of Couple Therapy for Anxiety

Many of the interventions described earlier in the treatment of depression also apply in treating anxiety and therefore are not repeated in this section. For example, FFT-AD (Chambless, 2012) has much in common with couple therapy for depression, including communication and problem-solving training. Topics for conversation can include how anxiety has impacted both partners and their relationship and how to incorporate treatment interventions into their lives, which can help increase cohesion, reduce blame, and counteract avoidance (Baucom et al., 2020).

As described by Abramowitz and Baucom (2020) and Baucom and colleagues (2020), key components of treatment involving a partner in the treatment of anxiety disorders include (1) psychoeducation—in which accurate information about the disorder is provided that may help to normalize anxiety, thereby reducing criticism and blame of the anxious partner and reducing accommodation by increasing understanding of exposure-based principles; (2) partner-assisted exposure—to provide support for exposure work in which the partner acts as a coach; and (3) reduction of accommodation—by directly helping the partner decrease accommodation behaviors. Within each of these domains, careful attention is paid to the function of anxiety-driven behavior and accommodation, the communication skills of the partners, the need for partners to work as a team, and the motivation of both partners for the anxious person to live a life in which decisions are not anxiety driven.

Psychoeducation should focus on the same components as when working with an individual. These include providing education about emotions and the adaptive nature of anxiety, presenting the cognitive-behavioral formulation of anxiety and its maintenance, and presenting the rationale for exposure therapy. In doing so with a couple, the therapist is not only working to help the anxious partner develop a better understanding of their anxiety, but also to help the nonanxious partner understand their anxious partner in a more empathic manner. As such, psychoeducation is explicitly directed at both partners and actively engages the nonanxious partner in discussing the material. People who do not experience anxiety can have a difficult time understanding how significant it is, and that it cannot just be stopped. Indeed, anxious people often report that their partners tell them to "just stop being anxious" or "there's nothing to be anxious about." Successful psychoeducation helps the nonanxious partner see that the anxious partner is not to blame and cannot just stop being anxious. In addition, when discussing exposure therapy, it is important that nonanxious partners see the benefits of this work, as they may initially assume that participating in exposure work may inflict pain or harm on their partner. As with any couple therapy, it also is important to set clear expectations for what can and cannot be achieved. Both partners may want anxiety to "go away," but both must agree that this is not a realistic goal.

In conducting partner-assisted exposure, it is important to help both partners clarify their roles and responsibilities. The nonanxious partner is typically encouraged to adopt the role of coach and taught to provide emotional support to their anxious partner in a kind but firm manner. Importantly, partners are taught to "unify against the problem." Specifically, it is typically helpful for them to view anxiety as a problem that they, as a couple, can manage. This puts the partners on the same side rather than in conflict with one another. Couples should be taught to plan exposures through explicit discussion of exactly what is to be done, what are each partner's responsibilities, what barriers may arise, and how to problem-solve barriers. Couples should debrief following the exposure to assess how it went and what may need to be done differently.

Managing accommodation behaviors may occur both during exposure or separately. Helping couples reduce accommodation may call for continual review of relevant psychoeducation. As with exposure work, therapists help couples work through barriers and problems. Having a clear understanding of the function of accommodation is necessary, which will also allow for replacement by behaviors that serve positive functions. For example, if accommodation is done as a way of showing care for the partner, new caring behaviors will be needed and must be agreed upon by both partners. In both managing accommodation and engaging in exposures, helping nonanxious partners to tolerate their own and their partner's emotional distress is critical. It can be difficult to see one's partner anxious, upset, and struggling. Helping the nonanxious partner remember the long-term goals and develop trust that their partner's anxiety is not dangerous may help reduce their own distress. For example, a therapist may say, "When you help with that, we know it's because you love him and don't want to see him suffer, but really your help is hurting because it keeps anxiety strong. What are other ways to show that you love and care?" Such a conversation might lead to something such as "Okay, so when he doesn't help you, are you willing to see that as loving and not as rejecting, especially if he tells you how much he loves how strong you're being in facing your anxiety? And can you [addressing the nonanxious partner] help yourself to remember that he can manage his anxiety, that as bad as it might seem right now, this is going to make life better for the both of you going forward?"

MECHANISMS OF CHANGE

Treatment of Depression

Does change in relationship quality mediate the effect of couple therapy on depression? The answer appears to be "yes." One study indicated that treatment changes in relationship discord were significantly associated with treatment changes in depressive symptoms for people receiving couple therapy (Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991). Moreover, another study indicated that the effect of couple therapy on depressive symptoms was mediated by change in relationship discord based on the following results: (1) Couple therapy resulted in changes in relationship discord and depression, relative to a wait-list control group; (2) change in level of relationship discord was correlated with change in level of depression; and (3) treatment group status was no longer significantly associated with change in depression, once controlling for change in relationship discord (Beach & O'Leary, 1992). Finally, in a study examining the degree to which change in relationship discord was associated with change in depression in couples who received cognitive-behavioral couple therapy for depression in routine clinical settings, decrease in relationship discord from pre- to posttreatment was associated with decrease in depressive symptoms at posttreatment, adjusting for severity of depressive symptoms at pretreatment (Baucom et al., 2018).

It appears, therefore, that couple therapy may reduce level of depressive symptoms primarily by reducing relationship discord, and not for some other reason. Hence, any intervention that reduces relationship discord and promotes couple cohesion is also likely to reduce depression.

Treatment of Anxiety

There is little research on treatment mechanisms for couple therapy for anxiety. However, a number of potential mechanisms are common across the anxiety disorders. Accommodation of the person's anxiety symptoms is a typical and problematic reaction exhibited by family member (Abramowitz & Baucom, 2020; Chambless, 2012). Accommodation may not only maintain or exacerbate anxiety symptoms but it may also result in conflict between partners that, itself, may maintain or worsen anxiety symptoms. Reduction of accommodation behaviors and of relationship conflict therefore may be fruitful targets to examine as treatment mechanisms. Partners of people with OCD reduced their accommodation behavior following couple therapy in one study, although mediation was not tested (Abramowitz et al., 2013).

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

General Considerations

Couple therapy for depression or anxiety may not be appropriate for every couple in which one partner is depressed or anxious. As a consequence, therapists must decide whether couple therapy makes sense for a couple given the particular circumstances, the particular symptom picture, and the state of the relationship at this particular point in time. Couple therapy for depression or anxiety is often appropriate, either as a stand-alone intervention or in conjunction with other interventions, when (1) the risk of suicidal behavior is relatively low; (2) neither partner is experiencing a bipolar disorder or a delusional disorder; (3) neither partner has indicated an immediate desire to separate or divorce, refused to work on improving the relationship, or indicated the intention to start or maintain an extradyadic sexual relationship; and (4) there is no evidence of moderate to severe levels of IPV.

We do not believe that the presence of low-level partner aggression needs to preclude use of couple therapy, so we accept couples for treatment of depression even if there is some report of low-level verbal or physical aggression. (See also Chapter 17 on partner aggression, in this volume, by Epstein et al.). However, we recommend referring couples for specific violence-focused intervention if they engage in moderate to severe IPV or if either partner feels unsafe due to the IPV. When low-level partner aggression is present and a couple is accepted into treatment, it is important to make sure that the aggression is not the primary issue in the relationship, that both partners feel safe talking about issues with each other, and that both partners sign a no-violence contract.

Depressed or anxious individuals often receive other treatments (e.g., medication) concurrently with couple therapy. When there is concurrent treatment, it is important that the couple therapist and the other treatment provider(s) maintain contact with each other. The potential for other treatment to interfere with couple therapy—even if the former is focused on medication maintenance—is substantial. For example, individual treatment providers may inadvertently encourage partner blame or poorly timed assertive reactions to the partner, potentially throwing off the timing of interventions with the couple. Ideally, a concurrent treatment is conducted by a provider who is well known to the couple therapist and with whom collaborative treatment and consultation are possible. Issues regarding confidentiality should be discussed in advance with both the couple and the person(s) providing the concurrent treatment.

Treatment of Depression

Variables that predict a relatively better response to one sort of treatment than to another are of great interest clinically. O'Leary and colleagues (1990) asked depressed women to rate which problem came first, the relationship discord or the depression. The more a depressed woman saw her depression as preceded by her relationship problems, the less likely her relationship improved if she received individual cognitive therapy; there was no association between event ordering and change in relationship quality for women who received couple therapy. Furthermore, ratings of temporal ordering were not predictive of change in depressive symptoms for either condition. These results suggest the potential value of assessing people's views of the factors contributing to their depression. For a depressed individual who believes that their relationship problems preceded the depression, and who is able and willing to work on relationship concerns, a treatment plan that relies entirely on individual therapy may produce unnecessary deterioration in relationship functioning. Whereas some researchers have most frequently focused on couple therapy for depressed individuals who were in discordant relationships, other researchers have examined the effectiveness of couple-based interventions for reducing depression among couples who are not necessarily dissatisfied with their relationship. For example, Bodenmann and colleagues (2008) found positive outcomes following coping-oriented couple therapy, which focuses primarily on the promotion of better dyadic stress communication, with the goals of enhancing mutual understanding of emotional stress experiences in partners and promoting dyadic coping that satisfies the needs of each partner. Cohen and colleagues (2010) obtained promising results for a brief, problem-focused couple intervention comprising five 2-hour sessions that uses psychoeducation and cognitive and behavioral techniques to reduce not only symptoms of depression in the depressed partner but also emotional distress in the nondepressed partner.

Researchers have examined the efficacy of couple therapy in reducing symptoms of both depression and relationship discord. Although behavioral and cognitive-behavioral approaches are the most common approaches that have been evaluated, other approaches have also been studied, including systemic couple therapy and emotionally focused couple therapy. (See also Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan.) A meta-analysis of 14 clinical trials that compared couple therapy for depression with individual psychotherapy (most often cognitive therapy), drug therapy, or no/minimal intervention found that (1) couple therapy improved depression at the end of treatment and after 6 months or longer and (2) there were no differences between couple therapy and individual psychotherapy with respect to remission rates or a continuous outcome of depressive symptoms (Barbato & D'Avanzo, 2020). Furthermore, couple therapy was more effective than individual therapy in reducing relationship discord at the end of treatment, and this difference was greater for discordant couples relative to nondiscordant couples. The study authors concluded that "couple therapy may be considered a viable option for the treatment of a depressed partner, especially in discordant couples" (p. 369). Reductions in depressive symptoms following couple therapy have also been found in couples who are not selected for the presence of a major depressive disorder (MDD; Doss, Roddy, Nowlan, Rothman, & Christensen, 2019).

Because we suspect that enhancement of relationship quality and interruption of vicious cycles maintaining depression are key to any successful approach to couple therapy for depression, it follows that any efficacious couple therapy approach has the potential to be efficacious in the treatment of depression as well. Accordingly, our approach to couple therapy for depression is open to the potential for alternative formats and innovative developments that may be useful for couples with particular characteristics.

Treatment of Anxiety

There has been relatively little work on identifying characteristics that could be used to inform decision making regarding treatment applicability for couple-based interventions specifically for anxiety. Similarly, with regard to predictors of treatment outcome, there is little research on couple therapy for anxiety disorders. In couple-based treatment for OCD, partners' heightened reactivity to emotional arousal of the person with OCD during a couple conversation about an OCD-related topic prior to treatment, which may indicate that partners have difficulty tolerating arousal in the person with OCD, evidenced smaller improvements (Fischer, Baucom, Abramowitz, & Baucom, 2022), and a higher level of partner accommodation at the end of treatment was associated with poorer response (Boeding et al., 2013). Given that accommodation may serve to reinforce anxiety, couple-based interventions may be indicated for couples in which the partner is accommodating to the person's anxiety, particularly if the nonanxious partner has difficulty abstaining from accommodation because they are highly reactive to their anxious partner's distress. In addition, higher levels of EE, particularly hostile criticism exhibited by family members, is associated with poor outcome to individual cognitive-behavioral treatment for anxiety disorders, including GAD, OCD, and panic disorder (Chambless, 2012). Hostile criticism also predicts relapse following individual treatment of OCD and panic disorder (Hooley, 2007). Couples who engage in hostile criticism, therefore, may be good candidates for couple-based interventions.

Recent research has begun to demonstrate the efficacy of couple and partner-assisted interventions for OCD. A pilot study examined the outcome of a 16-session couple-based treatment that focused on psychoeducation, partner-assisted exposure and response prevention, OCD-specific accommodation, and general relationship stressors (Abramowitz et al., 2013). Treatment was associated with posttreatment improvements in OCD symptoms, relationship functioning, and depression; improvements in OCD symptoms were maintained at 12-month follow-up.

There is relatively little research on the impact of couple therapy on reduction of symptoms of other anxiety disorders, but what does exist supports couple-based approaches. Initial research in this area indicates that couple therapy and partner-assisted therapy reduce symptoms of panic disorder and agoraphobia and can lead to improvements in relationship quality (Byrne et al., 2004). There also is evidence that couple therapy can lead to reductions in anxiety symptoms among couples who were not selected for the presence of anxiety disorders or symptoms (Doss et al., 2019; Durães, Khafif, Lotufo-Neto, & Serafim, 2020). With regard to GAD and SAD, there are no couple-based treatment outcome studies, although, as discussed earlier, a number of couple-based approaches grounded in adaptations of empirically supported treatments have been described.

CASE ILLUSTRATION

This case illustrates the treatment of a discordant couple in which one partner presented with both depression and anxiety. Kathy and Roy were in their early 60s when they presented to the clinic for treatment. They had been married for over 30 years and had two adult children who no longer lived at home. In the initial intake, Kathy reported a history of recurrent episodes of depression, with three episodes in the prior 20 years and persistent worry that began during adolescence. She denied suicidal ideation or intent and reported no history of other major psychiatric disorders except for meeting criteria for MDD and GAD; her symptoms of depression and GAD were moderate in severity. She was taking an antidepressant but had never been in therapy before coming to the clinic. With respect to their relationship, both Roy and Kathy scored in the discordant range on self-report measures, and they agreed that their relationship problems had become more severe following the onset of the most recent episode of Kathy's depression. Roy worked long hours, and they both reported being uncomfortable when together; consequently, they largely avoided each other. For Kathy, this led to increased anxiety and rumination about their relationship, believing that Roy did not care about her. Kathy spent all her time at home seeing no one but Roy. Roy reported feeling pressured to continually reassure Kathy that he cared about her.

The therapist began therapy by encouraging the couple to increase their frequency of caring behaviors and shared enjoyable activities. Both partners initially had difficulty initiating positive behaviors and activities, primarily because their feelings of hopelessness led to procrastination, and for Kathy, worry. The therapist discussed how change in behavior can lead to change in feelings and encouraged the couple to view the assignment as an experiment, to see what impact increasing caring behaviors and shared positive activities might have. In addition, the therapist suggested that the couple adopt the "5-minute rule" in which they would try a behavior for just 5 minutes, and if they felt like stopping at the end of that time, they could. The therapist explained that getting started is often the hardest part of initiating new activities.

In the following session, the couple reported that although doing the caring behaviors felt awkward at first, the activities had a bigger positive impact on their relationship than they had expected. Roy built Kathy a birdhouse, as watching birds was one of her favorite pastimes; Kathy bought Roy a book she remembered him mentioning several times he wanted to read. In the following days, they did several more caring behaviors, and the therapist worked closely with the couple to work out the details of a larger, joint positive activity, going out together. In the next session, they reported their "date" had gone well. They also decided to start a biweekly "date night," in which they would take turns coming up with something fun to do together (e.g., going to a new restaurant or attending a play).

The therapist also discussed the idea of self-esteem support. The couple agreed that this would likely be helpful, as they rarely complimented each other. They agreed to try to say at least one nice thing to each other during breakfast each morning, to ask each other about what they had done during the day when they walked their dog each evening, and each night before going to bed, to thank each other for something they noticed the other person did during the day.

In the following sessions, to decrease her reliance on Roy, the therapist focused on helping Kathy identify some activities she could do for herself. The therapist educated Kathy on the importance of engaging in these activities regardless of whether she was feeling depressed or anxious, and encouraged her to see if she could disengage from her worries and focus on the new activities. Kathy reported that she enjoyed photography but hadn't done anything with it for a long time. She joined a nature photography group that she met up with for nature photography walks on a regular basis. In addition, she started listening to podcasts about topics that interested her and volunteered to work 1 day a week at a food bank. Roy helped reinforce Kathy's engagement in these activities by encouraging her to pursue one of the activities on days when she was feeling low and by asking about these activities during their evening walk with their dog. At the end of six sessions, the couple reported feeling closer with each other and better about their relationship. Kathy reported fewer symptoms of depression. She also reported increased ability to disengage from ruminative worries and was happy that Roy was able to join her in listening to parts of her favorite podcasts on several occasions.

The therapist also introduced the idea of reducing Kathy's reassurance seeking and Roy's perfunctory verbal statements of caring in response to her prompts. The therapist explained that although accommodating requests for reassurance is an understandable and well-meaning response by partners, and it seems on the surface like it should be helpful, it actually serves to maintain and strengthen the very pattern of worry and uncertainty that it is meant to help. In addition, the therapist noted that it can lead to the person giving the reassurance becoming less and less convincing over time as they repeat the same thing over and over. Roy and Kathy agreed that this description captured their own interactions very well, which led to a discussion of possible ways for Roy to better respond to Kathy's requests for reassurance that he loved her. Ultimately, they agreed that they would work together, so that Kathy would no longer request reassurance from Roy, recognizing that it was counterproductive to her feeling better. They also agreed that Roy would support her in this by gently reminding her of their agreement when she did ask. As an alternative to asking for reassurance, Roy and Kathy also worked together to generate a set of cards that Kathy could select from when she would normally feel the need to ask Roy for reassurance. The cards contained reality-based statements about their relationship and coping statements. For example, one card reminded Kathy of specific ways Roy showed her his caring every day. This functioned to help Kathy feel more secure and to reduce her reassurance seeking behavior, which allowed them both to feel better about their relationship.

Therapy then focused on communication and problem-solving training. Because of some of the gains made earlier in therapy, both partners reported it was now easier to make the changes required for improving their problem-solving interactions. The therapist first worked with them on expressive and receptive communication skills. They practiced these skills while talking with one another about some remodeling they were considering for their kitchen. They then switched to talking about some ongoing problems both of them were having with a relative. During this conversation, Kathy got teary and didn't make eye contact with Roy. The therapist asked what was going on with her, and she started crying and said that she felt that Roy was being critical of how she handled a recent conflict with this family member, and this triggered worries about his love for her and the future of their relationship. Roy said he was trying to be helpful in offering suggestions of ways to deal with the relative and hadn't meant to be critical. The therapist worked with the couple to help them understand the importance of listening to each other without offering solutions or suggestions of how to deal with a situation unless such suggestions were requested.

Therapy then progressed to problem-solving and decision-making training, specifically focused on helping the couple work on problems in their relationship and, when requested, in other situations as well. The therapist actively coached the couple about how to phrase their concerns as problems to be solved rather than as personal attacks or criticisms. Similarly, the therapist worked with the couple to make sure each partner listened and validated the other person's perspective or opinion on the problem. They particularly benefited from learning ways of bringing up problems in a nonjudgmental, nonthreatening way, as their natural tendency had been to avoid bringing up problems for fear of upsetting each other, which left them feeling helpless and hopeless about making changes in their relationship. By the end of this stage of therapy, they reported that they were optimistic that they could use the problem-solving framework they had learned in therapy to address other ongoing problems in their relationship, as well as new problems that might come up. At the end of this stage, Kathy's depressive symptoms were in the normal range, she reported being better able to manage her anxiety, and both partners' relationship discord had improved.

Therapy ended with a focus on maintenance. Each partner wrote down in their own words what they learned in therapy and had found most useful, and they put these notes in a binder with their therapy handouts and other materials. The therapist encouraged the couple to think about issues or problems that might occur in the following weeks and months, and to problem-solve how to deal with upcoming challenges in advance. The therapist scheduled booster sessions with the couple for 6 and 12 months after treatment. They attended both booster sessions and reported that these sessions were helpful in reminding them to continue with the changes they had made during therapy and to apply the skills they had learned in therapy to new circumstances. Although the therapist offered to meet with them again 1 year later, the couple declined the appointment, saying they were doing well and felt confident in their relationship and their ability to handle future problems together as a team.

CONCLUDING COMMENTS

Since Beach and colleagues (1990) published their couple discord model of depression, scientific understanding of the role of intimate relationship functioning on depression has grown considerably (see Whisman et al., 2021), and intervention research has demonstrated that couple therapy is effective in treating depression (Barbato & D'Avanzo, 2020). Although there has been less research evaluating couple-based treatments for anxiety disorders, the intervention research that has been done supports their efficacy. Given that relationship discord frequently co-occurs with depression or anxiety, and that relationship difficulties, depression, and anxiety are among the most frequently encountered problems for which people seek treatment (Northey, 2002), the use of couple interventions shows great promise for not only improving a couple's relationship quality but also reducing their depression or anxiety.

SUGGESTIONS FOR FURTHER STUDY

Depression

Beach, S. R. H., Sandeen, E. E., & O'Leary, K. D. (1990). *Depression in marriage: A model for etiology and treatment*. New York: Guilford Press.

Whisman, M. A., & Beach, S. R. H. (2012). Couple therapy for depression. *Journal of Clinical Psychology, 68,* 526–535.

Whisman, M. A., Sbarra, D. A., & Beach, S. R. H. (2021). Intimate relationships and depression: Searching for causation in the sea of association. *Annual Review of Clinical Psychology, 17,* 233–258.

Anxiety

Abramowitz, J. S., & Baucom, D. H. (2020). Interpersonal processes. In J. S. Abramowitz & S. M. Blakey (Eds.), *Clinical handbook of fear and anxiety: Maintenance processes and treatment mechanisms* (pp. 219–237). Washington, DC: American Psychological Association.

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. E. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach*. New York: Routledge.

Chambless, D. L. (2012). Adjunctive couple and family intervention for patients with anxiety disorders. *Journal of Clinical Psychology, 68,* 548–560.

REFERENCES

Abramowitz, J. S., & Baucom, D. H. (2020). Interpersonal processes. In J. S. Abramowitz & S. M. Blakey (Eds.), *Clinical handbook of fear and anxiety: Maintenance processes and treatment mechanisms* (pp. 219–237). Washington, DC: American Psychological Association.

Abramowitz, J. S., Baucom, D. H., Boeding, S., Wheaton, M. G., Pukay-Martin, N. D., Fabricant, L. E., . . . Fischer, M. S. (2013). Treating obsessive–compulsive disorder in intimate relationships: A pilot study of couple-based cognitive-behavior therapy. *Behavior Therapy, 44,* 395–407.

Abramowitz, J. S., Deacon, B. J., Olatunji, B. O., Wheaton, M. G., Berman, N. C., Losardo, D., . . . Hale, L. R. (2010). Assessment of obsessive–compulsive symptom dimensions: Development and evaluation of the Dimensional Obsessive–Compulsive Scale. *Psychological Assessment, 22,* 180–198.

Alden, L. E., & Taylor, C. T. (2004). Interpersonal processes in social phobia. *Clinical Psychology Review, 24,* 857–882.

Antony, M. M., & Rowa, K. (2005). Evidence-based assessment of anxiety disorders in adults. *Psychological Assessment, 17,* 256–266.

Barbato, A., & D'Avanzo, B. (2020). The findings of a Cochrane meta-analysis of couple therapy in adult depression: Implications for research and clinical practice. *Family Process, 59,* 361–375.

Barton, A. W., Lavner, J. A., Sutton, N. C., McNeil Smith, S., & Beach, S. R. H. (2022). African Americans' relationship quality and depressive symptoms: A longitudinal investigation of the Marital Discord Model. *Journal of Family Psychology.* [Epub ahead of print]

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. E. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach.* New York: Routledge.

Baucom, D. H., Fischer, M. S., Worrell, M., Corrie, S., Belus, J. M., Molyva, E., & Boeding, S. E. (2018). Couple-based intervention for depression: An effectiveness study in the National Health Service in England. *Family Process, 57,* 275–292.

Beach, S. R. H., Katz, J., Kim, S., & Brody, G. H. (2003). Prospective effects of marital satisfaction on depressive symptoms in established marriages: A dyadic model. *Journal of Social and Personal Relationships, 20,* 355–371.

Beach, S. R. H., & O'Leary, K. D. (1992). Treating depression in the context of marital discord: Outcome and predictors of response of marital therapy versus cognitive therapy. *Behavior Therapy, 23,* 507–528.

Beach, S. R. H., Sandeen, E. E., & O'Leary, K. D. (1990). *Depression in marriage: A model for etiology and treatment.* New York: Guilford Press.

Beach, S. R. H., & Whisman, M. A. (2012). Affective disorders. *Journal of Marital and Family Therapy, 38,* 201–219.

Benson, L. A., Doss, B. D., & Christensen, A. (2018). Online intervention for couples affected by generalized anxiety disorder. *European Journal of Counselling Psychology, 7,* 1–13.

Bodenmann, G., Plancherel, B., Beach, S. R. H., Widmer, K., Gabriel, B., Meuwly, N., . . . Schramm, E. (2008). Effects of coping-oriented couples therapy on depression: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 76,* 944–954.

Boeding, S. E., Paprocki, C. M., Baucom, D. H., Abramowitz, J. S., Wheaton, M. G., Fabricant, L. E., & Fischer, M. S. (2013). Let me check that for you: Symptom accommodation in romantic partners of adults with obsessive–compulsive disorder. *Behaviour Research and Therapy, 51,* 316–322.

Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry, 55,* 547–552.

Byrne, M., Carr, A., & Clark, M. (2004). The efficacy of behavioral couples therapy and emotionally focused therapy for couple distress. *Contemporary Family Therapy, 26,* 361–387.

Cano, A., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of nonspecific depression and anxiety. *Journal of Consulting and Clinical Psychology, 68,* 774–781.

Chambless, D. L. (2012). Adjunctive couple and family intervention for patients with anxiety disorders. *Journal of Clinical Psychology, 68,* 548–560.

Cohen, S., O'Leary, K. D., & Foran, H. (2010). A randomized clinical trial of a brief, problem-focused couple therapy for depression. *Behavior Therapy, 41,* 433–446.

Davila, J., Bradbury, T. N., Cohan, C. L., & Tochluk, S. (1997). Marital functioning and depressive symptoms: Evidence for a stress generation model. *Journal of Personality and Social Psychology, 73,* 849–861.

Davila, J., Karney, B. R., Hall, T. W., & Bradbury, T. N. (2003). Depressive symptoms and marital satisfaction: Within-subject associations and the moderating effects of gender and neuroticism. *Journal of Family Psychology, 17,* 557–570.

Doss, B. D., Roddy, M. K., Nowlan, K. M., Rothman, K., & Christensen, A. (2019). Maintenance of gains in relationship and individual functioning following the online OurRelationship program. *Behavior Therapy, 50,* 73–86.

Durães, R. S. S., Khafif, T. C., Lotufo-Neto, F., & Serafim, A. D. P. (2020). Effectiveness of cognitive behavioral couple therapy on reducing depression and anxiety symptoms and increasing dyadic adjustment and marital social skills: An exploratory study. *Family Journal, 28,* 344–355.

Fischer, M. S., Baucom, D. H., Abramowitz, J. S., & Baucom, B. R. W. (2022). Interpersonal emotion dynamics in obsessive–compulsive disorder: Associations with symptom severity, accommodation, and treatment outcome. *Couple and Family Psychology: Research and Practice.* [Epub ahead of print]

Hammen, C. (1991). Generation of stress in the course of unipolar depression. *Journal of Abnormal Psychology, 100,* 555–561.

Hooley, J. M. (2007). Expressed emotion and relapse of psychopathology. *Annual Review of Clinical Psychology, 3,* 329–352.

Hooley, J. M., & Teasdale, J. D. (1989). Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology, 98,* 229–235.

Jacobson, N. S., Dobson, K., Fruzzetti, A. E., Schmaling, K. B., & Salusky, S. (1991). Marital therapy as a treatment for depression. *Journal of Consulting and Clinical Psychology, 59,* 547–557.

Joiner, T. E., Jr. (2000). Depression's vicious scree: Self-propagating and erosive processes in depression chronicity. *Clinical Psychology: Science and Practice,* 7, 203–218.

Joiner, T. E., Walker, R. L., Pettit, J. W., Perez, M., & Cukrowicz, K. C. (2005). Evidence-based assessment of depression in adults. *Psychological Assessment, 17,* 267–277.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 617–627.

Knobloch, L. K., Knobloch-Fedders, L. M., & Yorgason, J. B. (2018). Communication of military couples during deployment predicting generalized anxiety upon reunion. *Journal of Family Psychology, 32,* 12–21.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32, 509–515.*

Leach, L. S., Butterworth, P., Olesen, S. C., & Mackinnon, A. (2013). Relationship quality and levels of depression and anxiety in a large population-based survey. *Social Psychiatry and Psychiatric Epidemiology, 48,* 417–425.

Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin, 9,* 371–375.

McGrath, J. J., Lim, C. C. W., Plana-Ripoll, O., Holtz, Y., Agerbo, E., Momen, N. C., . . . De Jonge, P. (2020). Comorbidity within mental disorders: A comprehensive analysis based on 145 990 survey respondents from 27 countries. *Epidemiology and Psychiatric Sciences, 29,* Article E153.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73,* 1092–1106.

Northey, W. F., Jr. (2002). Characteristics and clinical practices of marriage and family therapists: A national survey. *Journal of Marital and Family Therapy, 28,* 487–494.

O'Leary, K. D., Riso, L. P., & Beach, S. R. H. (1990). Attributions about the marital discord/depression link and therapy outcome. *Behavior Therapy, 21,* 413–422.

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire—Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment, 8,* 443–454.

Overbeek, G., Vollebergh, W., de Graaf, R., Scholte, R., de Kemp, R., & Engels, R. (2006). Longitudinal associations of marital quality and marital dissolution with the incidence of DSM-III-R disorders. *Journal of Family Psychology, 20,* 284–291.

Porter, E., Chambless, D. L., Keefe, J. R., Allred, K. M., & Brier, M. J. (2019). Social anxiety disorder and perceived criticism in intimate relationships: Comparisons with normal and clinical control groups. *Behavior Therapy, 50,* 241–253.

Przeworski, A., Newman, M. G., Pincus, A. L., Kasoff, M. B., Yamasaki, A. S., Castonguay, L. G., & Berlin, K. S. (2011). Interpersonal pathoplasticity in individuals with generalized anxiety disorder. *Journal of Abnormal Psychology, 120,* 286–298.

Rector, N. A., Katz, D. E., Quilty, L. C., Laposa, J. M., Collimore, K., & Kay, T. (2019). Reassurance seeking in the anxiety disorders and OCD: Construct validation, clinical correlates and CBT treatment response. *Journal of Anxiety Disorders, 67,* Article 102109.

Rehman, U. S., Gollan, J., & Mortimer, A. R. (2008). The marital context of depression: Research, limitations, and new direction. *Clinical Psychology Review, 28,* 179–198.

Renshaw, K. D. (2008). The predictive, convergent, and discriminant validity of perceived criticism: A review. *Clinical Psychology Review, 28,* 521–534.

Segrin, C. (2000). Social skills deficits associated with depression. *Clinical Psychology Review, 20,* 379–403.

South, S. C., Krueger, R. F., & Iacono, W. G. (2011). Understanding general and specific connections between psychopathology and marital distress: A model based approach. *Journal of Abnormal Psychology, 120, 935–947.*

Spencer, C., Mallory, A. B., Cafferky, B. M., Kimmes, J. G., Beck, A. R., & Stith, S. M. (2019). Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychology of Violence, 9,* 1–17.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166,* 1092–1097.

Starr, L. R., & Davila, J. (2008). Excessive reassurance seeking, depression, and interpersonal rejection: A meta-analytic review. *Journal of Abnormal Psychology, 117,* 762–775.

Whisman, M. A. (2007). Marital distress and DSM-IV psychiatric disorders in a population-based national survey. *Journal of Abnormal Psychology, 116,* 638–643.

Whisman, M. A., & Bruce, M. L. (1999). Marital dissatisfaction and incidence of major depressive episode in a community sample. *Journal of Abnormal Psychology, 108,* 674–678.

Whisman, M. A., Davila, J., & Goodman, S. H. (2011). Relationship adjustment, depression, and anxiety during pregnancy and the postpartum period. *Journal of Family Psychology, 25,* 375–383.

Whisman, M. A., Robustelli, B. L., & Labrecque, L. T. (2018). Specificity of the association between marital discord and longitudinal changes in symptoms of depression and generalized anxiety disorder in The Irish Longitudinal Study on Ageing. *Family Process, 57,* 649–661.

Whisman, M. A., Sbarra, D. A., & Beach, S. R. H. (2021). Intimate relationships and depression: Searching for causation in the sea of association. *Annual Review of Clinical Psychology, 17,* 233–258.

Whisman, M. A., Snyder, D. K., & Beach, S. R. H. (2009). Screening for marital and relationship discord. *Journal of Family Psychology, 23,* 247–254.

Whisman, M. A., & Uebelacker, L. A. (2009). Prospective associations between marital discord and depressive symptoms in middle-aged and older adults. *Psychology and Aging, 24,* 184–189.

World Health Organization. (2017). *Depression and other common mental disorders: Global health estimates*. Geneva, Switzerland: Author.

CHAPTER 27

Couple Therapy with Parents of Youth with Attention-Deficit/Hyperactivity Disorder or Disruptive Behavior Disorders

Frances A. Wymbs, Brian T. Wymbs, and Will H. Canu

BACKGROUND

One of the realities of therapy that pertains specifically to couples that also have children is that a complicated system is involved, as the dynamics of relationships between each parent and (each) child, and between the parents themselves, are intertwined. Furthermore, each parent's perspective on the behavior, personality, strengths, and weaknesses of their child or children is different, sometimes markedly so. Each parent brings a set of experiences to this equation that also naturally varies.

As such, it is almost ubiquitous for parents to experience some conflict when rearing a child or children together (Cowan & Cowan, 2003). This arises even when children do not experience psychological or behavioral disorders. For instance, in one parent's family of origin, it may have been considered acceptable for children to interrupt an adult when they are speaking—a behavior that, up to a certain age, can be considered fairly normative. However, the other parent may have grown up in a household in which interrupting adult speakers was considered anathema and was met by harsh verbal or even physical punishment. In such a scenario, the question of how to handle interruptions in their own children might be one that thrusts the parents into disagreement. The extent to which this happens chronically and the manner in which a couple communicates and problem-solves such conflict likely determine whether child behavior and associated parenting responses become a source of couple dissatisfaction.

Of course, couple conflict associated with child behavior, related expectations, and parenting in response is almost certainly more frequent, severe, and difficult to resolve when offspring have their own personal challenges that impede satisfactory adjustment in important domains of life, or otherwise inherently frustrate parents. Many psychological disorders that emerge in childhood could present such hurdles. Several disorders catalogued in the fifth edition, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), including autism, anxiety disorders, and the newly minted disruptive mood dysregulation disorder, are associated with disruptive child behavior that is likely to add to parenting stress and challenge a couple's relationship.

While the behavior of children with such internalizing disorders certainly can pose difficulty to a couple's well-being, a more common disorder emerging in childhood that has been robustly associated with parenting and couple strain is attention-deficit/hyperactivity disorder (ADHD), which is the principal focus of this chapter. Historically, the syndrome that is captured in ADHD was first documented by Weikard in 1775, and at that time he conceptualized it largely as a failure in childrearing. While the "poor parenting" theory of ADHD has been replaced by theories that underscore executive dysfunction (Barkley, 2015) and other genetically and/or biologically mediated mechanisms (e.g., emotional dysregulation; Shaw, Stringaris, Nigg, & Leibenluft, 2014), it is clear that negative stigma related to ADHD is widespread (Speerforck et al., 2019), and this is something experienced by parents of affected children (dosReis, Barksdale, Sherman, Maloney & Charach, 2010). Complicating matters is that ADHD is very often comorbid with disruptive behavior disorders, such as oppositional defiant disorder (ODD; e.g., noncompliance to adult requests, vindictiveness) and/or the more serious conduct disorder (CD; e.g., initiating physical fights, lying), which also routinely exacerbate parenting distress.

This is all a backdrop for the presentation of a couple seeking services, one that also happens to have a child with disruptive behavior. While such couples—whether their child has ADHD, another disorder, or other psychological issues—may not initially focus on parenting, frustrations and disagreements regarding the child and their behavior may contribute to or even dominate the conflictual and dissatisfying aspects of their relationship. Based on our collective experience, it is far more likely that such a couple's relational issues will be brought to light in the context of one or both parents seeking therapeutic services to address their child's ADHD symptoms. In such therapies, the couple relationship emerges as a secondary concern in therapy.

This maps onto the "history" of couple therapy for parents of children who have ADHD or other disruptive behavior. Strictly speaking, interventions that have addressed these couples' relational concerns have to date been almost or completely subsumed in behavioral parent training (BPT)—loosely, a family-oriented approach to managing disruptive and distressing child behavior. There is a vast literature that suggests BPT is an efficacious intervention to address disruptive behavior related to ADHD (Evans, Owens, Wymbs, & Ray, 2018). However, while restoring positivity to parent–child interactions and relationships is quite often emphasized as an important component, there are very scant elements of these interventions that specifically focus on the relationship between parents. Therapists are generally encouraged to help parents to be "on the same page" when it comes to the implementation of specific parenting behaviors (e.g., selective attention to the child, systematic use of rewards, employing time-out as a disciplinary action), as inconsistency in this regard is likely to delay or disrupt child behavior change.

Unfortunately, achieving agreement between parents—and even securing the consistent involvement of both parents—is not always easy. The parents may not even agree that their child's behavior is fundamentally challenging (although this is uncommon in situations of clinically significant externalizing symptoms)! This is because, as mentioned earlier, each parent, no matter how long they have been together as a couple, brings a different "playbook" to the endeavor, a different set of expectations for child behavior and, likely, a different set of go-to parenting strategies that are reflexively used in various specific situations. Each parent brings a different personality and may in fact bring their own aspects of psychopathology. For example, owing to the heritable nature of ADHD (Faraone & Larsson, 2019), it is common for at least one parent of a child with ADHD to share historical and current difficulties with paying attention and regulating their impulsivity with their child. While this sometimes engenders parent–child sympathy and cooperation in therapy, in our experience, it also can be associated with a belief that runs along the lines of "Well, I did it, and without much support, so my kid should be able to, also." In all of this, the possibility of marked dissatisfaction and conflict between the parents is substantial.

Hence, this chapter is, by necessity, different from many others included in this *Handbook*. We cannot draw on a grand historical tradition of couple-based interventions for this population. However, we fervently believe that a focus on the couple in BPT interventions is, in many cases, sorely needed. Otherwise, conflict and dissatisfaction within the couple become obstacles to parent cooperation that is fundamentally necessary for successful treatment of child ADHD and other disruptive behavior, and also clearly is detrimental to familial adjustment in its own right. In fact, teaching parents to join around the mutual purpose of helping their child, to communicate more effectively, and to maintain as positive an outlook as possible relative to each other and the situation is integral to a much wider range of child therapy issues (i.e., well beyond ADHD). As such, our aim is to provide some guidance to therapists on how to successfully navigate couples' issues in such instances and to ground this guidance in the empirical literature as much as possible, but to use the lens of ADHD to draw on our own specific experiences with couples whose children have had serious behavioral disturbance.

CORE UNDERSTANDINGS ABOUT THIS POPULATION

ADHD is a common behavioral disorder that, according to DSM-5-TR (American Psychiatric Association, 2022) emerges in childhood (i.e., < 12 years old) and has cardinal features of inattention (IA) and/or hyperactivity–impulsivity (HI) that are age-inappropriate and cause chronic and substantial impairment across several life domains (e.g., impaired relations with peers and adults, academic struggles). The disorder is frequently identified in early elementary school, when children encounter difficulties with social adjustment due to rule-breaking behaviors related to HI, as well as those more characteristic of IA (e.g., failing to follow through on age-appropriate instructions), or if they are not performing up to grade level academically. Children with ADHD often have comorbid conditions (e.g., ODD, CD, learning disabilities; Barkley, 2015), which further increase the severity of their social and academic difficulties. As affected children mature into adolescence, impairment in social and academic domains tends to persist and often broadens to include engagement in problematic behavioral experimentation with peers (e.g., precocious sexual behavior, early alcohol and illicit drug use). Presentation of ADHD symptoms may shift across childhood as well, with more of an emphasis on visibly hyperactive behavior in younger children, whereas older teens may have developed the cognitive and brain maturity to suppress such actions when called for but instead report highly elevated restlessness. Both boys and girls are affected by ADHD, but the former outnumber girls substantially in terms of diagnoses (a ratio of 2:1 to 3:1, conservatively), perhaps due to differential presentations, with girls tending to present with predominant IA and boys featuring more prominent HI (American Psychiatric Association, 2013).

The "playbook" with which most parents are initially and naturally equipped to raise a child falls short of the kind of structure, support, and understanding that a child (or adolescent) with ADHD needs to succeed across daily tasks and interactions. It follows that the typical parent will likely experience high frustration with their child with ADHD, and this sets relational dynamics in motion that present high risk for parent–child negativity. Johnston and Chronis-Tuscano (2015) document how families of children with ADHD are characterized by high stress and conflict, and that parents more frequently engage in behaviors (e.g., judgmental or critical comments, harsh and/or inconsistent discipline, overcontrolling or lackadaisical parenting) that exacerbate their child's symptoms and also engender negative feelings. Unfortunately, this type of pattern is only made worse in the case of comorbid ODD/CD (Deault, 2010). Generally speaking, parents (with mothers being most studied) have been observed to act more negatively toward their children with ADHD, particularly in demanding kinds of ways. Ecological momentary assessment techniques have in fact revealed that mothers perceive disagreements with their children with ADHD to occur five times more often than do mothers with neurotypical children, and anger is endorsed seven times more often in those interactions (Whalen et al., 2006).

This kind of dynamic in the home, obviously, adds dramatically to parenting stress, a toll that seems likely to be related to elevated risk for depression in mothers of children with ADHD (Chronis et al., 2003). Add into the mix parents' different perceptions of the child and their needs, different personal strategies for helping (or just dealing with) the child that have varying effects, experience of "affiliate" stigma related to having a child with ADHD and other behavioral issues (Mikami, Chong, Saporito, & Jiwon Na, 2014), and the sum is a potential "powder keg" for disrupting couple satisfaction and closeness. Indeed, evidence suggests that divorce and separation rates in couples with children with ADHD do tend to be higher (Wymbs et al., 2008), which is likely due at least in part to the deleterious effects of managing chronic disruptive child behavior on interparental communication and problem-solving behavior (Wymbs & Pelham, 2010). Results regarding relational satisfaction in intact couples are surprisingly ambiguous, though, with some studies (e.g., Murphy & Barkley, 1996) suggesting lower levels than in comparison couples with neurotypical children and other studies (e.g., Camparo, Christensen, Buhrmester, & Hinshaw, 1994) finding no differences. Some evidence suggests that there is heterogeneity in this regard across presentations of ADHD, whereby cases with particularly disruptive behavior (e.g., comorbid ODD/CD) are more likely to seriously impact the couple's relationship (Johnston & Chronis-Tuscano, 2015).

Given that heritable factors have long been recognized to contribute to risk for ADHD

(Faraone & Larsson, 2019), a factor that further complicates therapy with these couples is the possibility that one of the parents will meet criteria for ADHD, too. Adult ADHD brings a host of potential couple relationship problems, including negative conflict resolution styles (Canu, Tabor, Michael, Bazzini, & Elmore, 2014) and interpersonal violence and/or victimization (Wymbs, Dawson, Egan, & Sacchetti, 2019). Parents who themselves have elevated ADHD symptoms also tend to engage in more negative communication with their non-ADHD partners when managing disruptive, ADHD/ODD child behavior (Wymbs et al., 2017). Partners of individuals with ADHD almost always report perceiving shortcomings in other domestic duties and needing to take up that added slack (Eakin et al., 2004), which likely exacerbates a trend toward lower relational satisfaction and higher frequency of extramarital affairs (Barkley, Murphy, & Fischer, 2008). Some of the more common behaviors that partners of adults with ADHD underscore as upsetting include not remembering conversations, leaving a mess at home (IA-related), saying things without thinking (impulsivity-related) and not dealing well with frustration (affect regulation-related; Robin & Payson, 2002).

Add to this mix other common characteristics such as high risk for comorbidities that are quite disruptive to relational functioning (e.g., substance use, intermittent explosive, mood disorders; Kessler et al., 2005), and recent evidence of assortative mating that, at least theoretically, increases the chance of *both* parents having ADHD (Steele, Wymbs, & Capps, 2020). The scant available data unfortunately suggest that only a minority of adults with ADHD (in the United States, at least) receive ongoing treatment (pharmacological and/or psychosocial; Kessler et al., 2005), which in turn indicates that in few such cases would the symptoms and impairment related to ADHD be well managed in affected parents. All told, it should be clear that both intra- and interpersonal difficulties of couples presenting with a child with ADHD and related disruptive behaviors are likely to be numerous and intertwined, presenting significant challenge to the couple therapist.

THE PRACTICE OF COUPLE THERAPY WITH PARENTS OF YOUTH WITH ADHD OR DISRUPTIVE BEHAVIOR DISORDERS

Prior to describing best practices for working with distressed parent couples of children with ADHD and disruptive behavior disorders, it is important to consider relevant contextual factors. Most notably, how did this couple come to seek child-focused couple services? In our work as clinical child psychologists, the most typical referral reason for couple therapy is that the couple's child is a newly identified patient presenting with externalizing behavior problems and, as services for this child progress, the strain and potential for fracturing in the couple's relationship becomes evident. Couples on this *child services pathway* to child-focused couple therapy often argue about the need for therapy for their child (e.g., the mother seeing the need and initiating services, while the father is not on board because "Boys will be boys" or "I did the same stuff growing up, and I turned out okay"). They may also disagree repeatedly about strategies recommended to them for implementation at home. Though less common, another starting point is seeing an adult for ADHD treatment. As part of services for individuals on this *adult ADHD pathway* to child-focused couple therapy, adults with ADHD ultimately underscore the stress of being a parent, and how it spills over to impact their relationship with their co-parent. A third course, perhaps most common for typical couple therapists, is couples on the *couple counseling pathway* to child-focused couple therapy. These couples begin work to improve their relationship, but this ultimately reveals that one or both partners have ADHD and/or their children have disruptive behavioral issues that frequently spark their recurrent, severe, and difficult-to-resolve conflict. All three referral to child-focused service pathways lead to intervention for couple distress resulting from being parents of difficult-to-manage children.

That said, the treatment of couples in these different pathways will vary significantly. For example, couples in the child services pathway typically begin with some form of behavioral parenting intervention for their child, leading to the introduction of couple communication and problem-solving skills into sessions to strengthen the efficacy of their co-parenting. Notably, as often just one parent participates in the requisite child assessment and therapy, clinicians may need to facilitate inclusion of the co-parent to focus on the couple's relationship. Often it is logistical obstacles prohibiting both partners from attending (e.g., parents lack access to child care to make mutual parent attendance possible). In these instances in which only one of the two partners attend, the therapist must work with the other partner to ensure their understanding of the session and maximize consistency. It is also helpful for the therapist to have therapeutic alliances with both partners; thus, checking in with the partner who may not attend regularly (over phone, online, or video call) on a regular basis is prudent. Logistical obstacles may need to be addressed by clinicians to facilitate a shift to couple therapy (e.g., have clinic administrative staff watch the children; allow children to have screen time [on iPad, smartphone] in therapy room with parents and clinician). Otherwise, in the event that a partner is not involved for reasons other than logistics (e.g., disbelief that their child's behavior is a clinical problem or that treatment is needed), clinicians need to probe the participatory partner for the motive(s) behind their uninvolved partner's decision to not attend (e.g., persistent childrearing disagreements), then arm the participatory parent with bullet points for conversation with their partner to motivate them to consider joining the next session (e.g., "We will be talking about us, not our child"; "Strengthening our bond will spill over to strengthen our family bonds").

For couples in the adult ADHD pathway, the focus of therapeutic services expands from individual treatment to include partners and discussing skills beyond self-management (e.g., communication and problem solving with partner, responding as an effective co-parenting unit to difficult-to-manage child behavior). Similar to the child services pathway, there may be a need to navigate logistical and partner issues in the adult ADHD pathway before including partners in therapy sessions. Finally, for couples in the couple counseling pathway, where there is already a grounding in communication and problem-solving skills, among other foci (e.g., emotional acceptance/tolerance), the treatment focus will broaden in some ways (e.g., self-management of adult ADHD, learning effective child behavior management skills) and tighten in others (e.g., effective communication and problem solving *in the moment* of handling disruptive child behavior). Thus, though the techniques and recommendations we discuss below are useful for all pathways to child-focused couple therapy, the timing and method of delivery (and individuals involved in receiving it) may vary notably depending on the initial referral reason.

The Structure of the Therapy Process

Evidence-based treatment for children with ADHD includes behavioral interventions (e.g., BPT), stimulant medication, and/or their combination (Evans et al., 2018). Some forms of BPT for parents of young (3- to 8-year-old) children with ADHD include children as active participants in sessions (e.g., parent–child interaction therapy; Zisser & Eyberg, 2010), but most forms of BPT for preadolescents with ADHD do not. In the latter case, sessions are typically held weekly for 1 hour, only include parents or primary caregivers (e.g., grandparents), and nearly always have just an individual caregiver present for session. As such, the biggest shift in session structure to child-focused couple therapy with parents of preadolescents with ADHD and disruptive behavior is including the second parent in the sessions. Because this involves having both primary child care providers in the therapy session, clinicians will also have to navigate with parents how they will find care for their children during therapy sessions, or how their child(ren) can be adequately managed in the clinic during these sessions (e.g., sitting in waiting room with administrative staff monitoring behavior, including a child in therapy room big enough to allow room for child free play, having a volunteer or intern assistants play with children). Last, homework is generally assigned after each session, requiring parents to monitor and practice use of specific skills and treatment strategies for their child, and this is the focus of discussion at the beginning of the following session.

Evidence in support of psychosocial treatment for preadolescents with ADHD far outpaces what is known regarding best practices for treating adolescents with ADHD. Regarding the emerging evidence in support of effective interventions for adolescents with ADHD (Evans et al., 2018), training interventions (e.g., Evans et al., 2016) show the most promise for this population. Whereas behavioral interventions focus on adjusting behavioral contingencies in home or school by training adults in those settings (i.e., parents manipulating antecedents or consequences associated with target misbehavior), training interventions encourage adolescents to learn and utilize self-management skills through extensive practice of new or replacement behaviors until they become routine and part of the individual's daily habits (Evans et al., 2018). Contingencies are not manipulated by parents as a part of training interventions. As such, it may be less common for clinicians adhering to evidence-based treatment of adolescents with ADHD to work directly with parents; in such situations, there may be relatively less opportunity to discover and address couple issues. One exception might be clinicians who are conducting sessions with a focus on parent–teen negotiation work that, while less evidence-based, is a common approach taken by clinicians working with teens with ADHD and disruptive behavior disorders (e.g., Robin & Foster, 1989) in which autonomy-seeking and autonomy-granting issues underlie impairment at home and elsewhere. In the context of parent–teen negotiation services, owing to their work on building effective communication and problem-solving skills for difficult discussions with their adolescents, parents of teens with ADHD might be primed to reveal motivation to address similar difficulties with their partner/co-parent. In this case, there would be a structure in place to invite the partner into sessions with the parent who has been involved in therapy sessions with their teenager to engage in child-focused couple therapy work.

Relating to the adult ADHD pathway to child-focused couple therapy, the most evidence-based method for treating ADHD in adults is cognitive-behavioral treatment (CBT; Kooij et al., 2019). CBT for adult ADHD reviews skills to improve organization and behavioral self-control, as well as strategies to manage stress and harmful cognitions perpetuating task avoidance (Ramsay, 2010). Sessions are typically held weekly for one hour with homework assigned to enhance skill development between sessions. Some forms of CBT for adult ADHD include significant others for optional sessions (e.g., Safren, Sprich, Perlman, & Otto, 2017), but their role in treatment is typically minimal. In light of the difficulties adults with ADHD have with being self-sufficient (Barkley et al., 2008) and recognizing when their behavior is impaired (e.g., Knouse, Bagwell, Barkley, & Murphy, 2005), clinicians working with these adults are urged to engage with their romantic partners, who can play an important role in helping them recognize when their behavior is straining the relationship. For example, adults with ADHD are often impaired in their parenting (e.g., overly harsh and critical; Wymbs et al., 2017), but may be unaware of their difficulties. Engaging partners in therapy may allow for a frank problem-solving discussion of their co-parenting relationship and may yield effective solutions to their childrearing impairment that may not have otherwise been possible via typical individual CBT for adult ADHD.

The Role of the Therapist

In order to treat couple discord secondary to disruptive child behavior, the primary focus of therapists should be on improving the efficacy and consistency of co-parenting in response to child misbehavior. For this reason, therapists must have the ability to facilitate problem-solving discussions between the partners regarding childrearing issues, and the knowledge and creativity to successfully address both common and unique behavior management challenges that parents of children with ADHD and related disorders face every day.

Being creative and breathing life into behavioral treatments is critical, in that parents opting for individual therapy for child management reasons are often seeking help for childrearing issues they believe are unrelated to their parenting. For example, it is common for parents of children with ADHD and disruptive behavior disorders to assert that they have tried everything—even evidence-based interventions—with limited or no success, stymied by their child's "unique" behavioral difficulties (e.g., "Time-out does not work for my child"). This requires therapists to have large and flexible toolkits, including an infinite supply of suggestions they can make to parents for minor and major adjustments to behavior management plans for their children.

On a related note, the thought of repeatedly adjusting behavior management plans (e.g., behavioral targets, reward options) to address the idiosyncratic presentations of children with ADHD can also be overwhelming for many parents, leading to short-lived attempts at applying new parenting practices. This is an important issue because discontinuing interventions prematurely may ultimately reinforce child misbehavior and may make it even more difficult to achieve improvement down the road. As such, therapists also need to be adept at propping up parents with emotional scaffolding (aka "cheerleading") to encourage their early efforts to change and maintain these changes, and when working with parent couples. It is especially worthwhile to encourage and reinforce efforts the co-parents make to support each other's efforts to try and sustain new behavior management strategies in the face of chronic child misbehavior.

Parents of children with ADHD and related disorders often present as "defeated," with extremely low appraisal of their own parenting competence owing to repeated "losses" at the hands of their chronically difficult-to-manage children, and this deflated mood inevitably spills over to adversely affect their couple relationship. Parents who believe they have tried everything, even parenting interventions with other clinicians, are especially likely to present this way. Therapists who can empathize with the long-standing struggle parents of children with chronic disruptive behavior endure have a better chance of successfully meeting parents where they are, while also encouraging them to not give up and to try some new, potentially more effective approaches to managing their child's behavior. Doing so will establish a foundation for effectively targeting couple relationship issues secondary to childrearing concerns. Therapists seeking to target child-focused couple issues must be able to easily and effectively jump from addressing needs of the couple to the needs of the child, and vice versa. In fact, the ability to recognize which of the issues—child behavior or couple discord—is the larger "fire" at any given time during treatment, and the willingness to shift emphasis accordingly and rapidly, can mean the difference between progress and continuation versus the experience of backsliding and termination.

As part of the work of addressing parenting deficits in one parent or in parent couples, the clinician is typically leading sessions in a didactic way (i.e., being expert in the room, recommending evidence-based parenting strategies). However, there is almost always a need to adapt evidence-based behavioral treatments delivered to parents of children with ADHD to flexibly accommodate for contextual nuances that affect the course of treatment (e.g., having multiple children with behavioral issues, only one parent motivated to complete homework, one or more parents with ADHD or depression). For example, relevant contextual factors may indicate the need to alter the time line of treatment (e.g., recommending individual services for adult psychopathology prior to continuing services for their child). As such, it is in the best interests of the therapist to monitor relevant factors, such as waning/inconsistent parent attendance or homework completion, which provide clues regarding the investment the parents have in the course of treatment, then potentially adjust the delivery and expectations of treatment accordingly.

Assessment and Treatment Planning

The best course of assessment and treatment for couples experiencing childrearing stress and conflict depends on their pathway (child services, adult ADHD, or couple counseling). Rather than focusing on any particular pathway to child-focused couple work, we have chosen to present below essential assessment methods for clinicians who routinely provide couple therapy but may need consultation on individual services for children or adults with ADHD or disruptive behavior disorders.

Assessing for Child ADHD and Disruptive Behavior Disorders

Properly assessing the clinical significance of child behavioral issues requires a comprehensive multimethod, multi-informant assessment (Pelham, Fabiano, & Massetti, 2005). Clinicians should begin by conducting a functional behavioral assessment of two or three of the child's behaviors that are most concerning to the parents (e.g., noncompliance, aggressive behavior with siblings, disrespectful language). This entails asking parents to describe the behavioral issue in precise terms, including how often the child exhibits it, how long this has been going on, whether it has changed/worsened over time, how it may present differently with certain people or within particular situations, and how the child responds to different consequences (e.g., sibling laughter, parental reprimands). Special consideration should be paid to identifying recurrent triggers of the challenging behavior (e.g., happens more with the mom than the dad). The goals of this assessment are not only to shed light on the potential clinical significance of the disruptive behavior but also to distill potential motives of the misbehavior that could be targeted in treatment.

Upon having a clearer sense of the types of disruptive child behavior problems that are stressful for the parent couple, the therapist should conduct a semistructured clinical interview to identify additional, more distally related risk factors for the behavioral issues. Areas to assess include the developmental history of their child (e.g., pregnancy/birth concerns, walking or talking on time or delayed), family history of psychopathology (e.g., maternal depression, paternal antisocial personality disorder, parental substance abuse), and any history of child maltreatment or suicidal/homicidal ideation or behavior. This line of inquiry provides critical details regarding contextual factors relevant for possible diagnoses (e.g., evidence of genetic links) and potential concurrent targets for treatment.

Next, the therapist should have parents and teachers complete psychometrically sound broad-band and diagnostic symptom and impairment rating scales to further assess the severity of the behavioral issues and to identify potential comorbid conditions. Acknowledging the need to identify clinically significant symptoms across multiple settings, particularly areas of common impairment among youth with ADHD (e.g., academics, peer relations), teachers are crucial informants. Broad-band measures are useful not only to assess the relative severity of the problematic behavioral domains as compared to nonreferred same-age children but also to potentially identify comorbid conditions (e.g., depression and anxiety) that may require additional assessment and focus during treatment. Perhaps the most common parent-rated broad-band measure of child psychopathology is the Child Behavior Checklist (Achenbach, 2009), which also has a complementary teacher-rated version known as the Teacher Report Form. These measures are licensed and require purchase. The Strengths and Difficulties Questionnaire (Goodman, 1997), another high-quality broad-band measure of child psychopathology, has parent and teacher versions and is free of charge. The most up-to-date ADHD-specific rating scale assessing DSM-5 ADHD symptoms that has both parent and teacher versions is the ADHD Rating Scale–5 (DuPaul, Power, Anastopoulos, & Reid, 2016). This is licensed and requires purchase. A freely available measure of DSM ADHD, ODD, and CD symptoms with parent and teacher versions is the Disruptive Behavior Disorder Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992). Additionally, to confirm functional difficulties in one or more settings (e.g., home, school, peer) as required for ADHD diagnosis by DSM-5-TR, clinicians should consider administering a measure of ADHD-specific impairment. One such freely available parent and teacher measure designed to assess difficulties in home, school, and peer settings commonly observed in youth with ADHD and disruptive behavior disorders is the Impairment Rating Scale (Fabiano et al., 2006). Finally, for differential diagnosis purposes, particularly for ruling out internalizing disorders as potential explanations for externalizing behavior, it is recommended that clinicians conduct a structured interview of mood and anxiety disorders (e.g., Diagnostic Interview Schedule for Children, Kiddie Schedule for Affective Disorders and Schizophrenia, Children's Interview for Psychiatric Symptoms) and, for adolescents, of substance use disorders.

Assessing for Adult ADHD and Relevant Comorbid Conditions

Given the notable heritability of ADHD (Faraone & Larsson, 2019), clinicians working with parents of children with disruptive behavior problems should consider assessing both parents for ADHD and relevant comorbidities. Research suggests increased likelihood that at least one parent also has the disorder, and in light of emerging evidence underscoring assortative mating among adults with ADHD (Steele et al., 2020), many adults with ADHD will have partners with ADHD as well.

Consistent with available guidelines (Kooij et al., 2019), we recommend screening for ADHD in parents using the World Health Organization Adult ADHD Self-Report Scale (ASRS; Kessler et al., 2005). The original ASRS contains items assessing the 18 DSM diagnostic symptoms, and six of those items have been shown to be an effective screening tool. A more recent version includes updates for DSM-5 criteria and a refined six-item screener that has excellent sensitivity and specificity (Ustun et al., 2017). Parents who screen positive for ADHD on the ASRS screener could then complete the full ASRS and an empirically supported measure of ADHD-relevant impairment (e.g., Weiss Functional Impairment Rating Scale self-report; Weiss, 2000) to more thoroughly assess for a possible ADHD diagnosis.

Additionally, acknowledging the high degree of overlap between ADHD and other common mental health disorders in adults, most notably depressive and anxiety disorders, we recommend conducting an interview to both assist in differential diagnosis regarding current symptoms and assess for the presence of ADHD symptoms (and impairment) in childhood (specifically by age 12), which is necessary in order to consider diagnosing an adult with ADHD. Clinicians should also consider screening for other possible comorbid conditions and areas of impairment relevant for adults with ADHD in relationships. First, clinicians should consider screening for alcohol and illicit drug abuse (e.g., Alcohol Use Disorder Identification Test [AUDIT]; Reinert & Allen, 2007), as substance abuse is common and associated with impairment among adults with ADHD. Second, because of the elevated risk of violence in couple relationships in which one or both partners have ADHD, particularly within the context of alcohol abuse (Wymbs et al., 2019), and the deleterious consequences experienced by children witnessing domestic violence, it is recommended that clinicians screen for presence of intimate partner violence (e.g., Revised Conflict Tactics Scales; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Assessing for Relationship Dysfunction in the Context of Child and/or Adult ADHD

Once the extent of child or adult disruptive behavior problems has been determined, it is important to assess whether such problems adversely affect parenting and couple functioning, particularly during times when one or both parents are managing difficult child behavior. Beyond the assessment of basic couple-relevant indices (i.e., satisfaction, communication and problem-solving behavior; see also Chapter 2, "Couple Assessment," in this volume, by Snyder & Balderrama-Durbin), assessing for frequency and intensity of childrearing disagreements (Jouriles et al., 1991) and overt conflict in front of the child (Porter & O'Leary, 1980) at baseline would allow for an understanding of whether these behaviors are relevant concerns, as they often are in families of youth with ADHD and disruptive behavior disorders. Measuring pretreatment parenting distress (Abidin, 2012) and parenting self-esteem (Ohan, Leung, & Johnston, 2000) also help shed light on whether one or both parents may be weighed down by their role as parent.

In couples including one parent with ADHD, it is imperative to assess the burdens of the parent *without* ADHD. Commonly, these parents are not only responsible for more of the child management responsibilities owing to their partner being less able or willing to monitor or effectively discipline their children but they also potentially accommodate for their partner's behavioral deficits in areas beyond parenting (e.g., money management, household chores). They may need extra support from the therapist to persist with treatment amid all of their responsibilities. Finally, if space and facilities allow, it is useful to observe triadic interactions with both parents and child in relevant contexts (e.g., homework time, cleanup). Doing so allows the therapist to glean how parents work together to manage disruptive child behavior when it arises and, during the course of treatment, whether the parent couple is responsive to recommendations for adjusting their parenting approach and communication/problem-solving behavior with each other, particularly during moments when the child is misbehaving.

Goal Setting

The goals of an integrative approach that combines aspects of BPT plus couple therapy are established collaboratively by the parent(s) and therapist at the beginning of treatment. Because children and adolescents under evaluation for ADHD often have inaccurate appraisals of their own behavior (Owens, Goldfine, Evangelista, Hoza, & Kaiser, 2007), they are not typically involved in the goal-setting phase. However, teacher report is often solicited, and this report can also inform goals. As there is reason to believe limited insight observed in youth with ADHD improves during young adulthood, adults with ADHD are typically involved in goal setting for their treatment. Furthermore, there is no concern about adults with ADHD having difficulties fairly evaluating the behavioral concerns of their children, so their involvement in goal setting for their child's treatment should be sought.

Treatment goals are defined in the initial intake session, and these goals are shaped over time. Often, the referring parent or teacher will list problematic behaviors (e.g., noncompliance) and suggest adaptive alternatives (e.g., follows directions or compliance) or a decrease in the frequency, duration, or severity of the problematic behaviors (e.g., one or fewer instances of noncompliance in the morning). Therapists usually solicit parent input on the two to four behavioral challenges that they would like to begin targeting in treatment, usually higher-risk or more severe behaviors that they prioritize (e.g., noncompliance, aggression) versus those that are lower risk and less severe by comparison (e.g., interruptions, disorganization). Sometimes teachers' input suggests additional or alternative goals for the school setting (e.g., raising hand before asking questions). Additionally, the therapist may perceive ancillary goals that neither parents nor teachers suggested. This is especially true if parents present to treatment owing to concerns about their child's behavior but over the course of the initial assessment, the therapist also identifies communication and problem-solving issues between co-parents or symptoms of adult ADHD that negatively impact the child (e.g., through harsh and critical parenting behaviors or inconsistency between parents). If the therapist notes additional goals such as improving communication and problem solving between partners that the parents do not suggest, they use their judgment to determine whether to suggest these, ask openly about these areas of functioning and respond accordingly, or wait to make these areas of functioning treatment goals until the parents show insight or buy-in. The manner in which this is handled is different for each couple, depending on their responsiveness to feedback, insight, and other goals, and therapist uses their discretion in moving forward.

Process and Technical Aspects

Our approach when working with distressed parent couples rearing youth with ADHD and disruptive behavior disorders is to integrate BPT and integrative behavioral couple therapy (IBCT; see also Chapter 4, "Integrative Behavioral Couple Therapy," in this volume, by Christensen, Dimidjian, Martell, & Doss). The approach by which these treatment methods are combined is flexible, depending on the couple or comfort/skills level of the clinician. For example, with couples, when it becomes clear which area is the source of distress in the other domain (e.g., disruptive child behavior drives couple discord more than the reverse), sequencing the order of treatment foci to target the source of the distress first (i.e., starting a course of BPT to reduce incidences/severity of disruptive child behavior) could be most useful to the parent couple. This may also be the simplest path for beginning therapists, or at least those inexperienced at integrating these therapies. On the other hand, for couples in which the source/direction of distress is balanced, and clinicians are competent with both therapies, then interweaving both behavioral therapies into each session might be the best approach. Of course, if the balance shifts during the course of treatment, the therapist may need to adjust the focus to meet the couple/family where they are, redirecting treatment focus on the primary source of distress.

Regardless of the method by which these treatments are combined, all sessions are structured similarly. First, whenever possible, both parents are invited to participate in every session. There is significant value in getting information from the perspective of both partners regarding their child's disruptive behaviors and how they each parent the child. Even when parents' perspectives are consistent in many ways, any differences are important to know, so they can be enhanced (e.g., having both partners do something more effective) or reduced (e.g., asking one parent to discontinue a parenting practice that reinforces misbehavior, such as laughing).

Early sessions usually focus on goal setting and psychoeducation. The focus of psychoeducation varies across BPT programs, with some focusing on principles of behavioral modification (e.g., review ABCs—Antecedents, Behaviors and Consequences) and others focusing on underlying principles of effective parenting (e.g., what makes a great boss). Opening sessions also devote some time to discussion relevant to the couple, including reflection on early moments in their relationship and amplifying activities and behaviors that both partners enjoyed. Assigning homework (and expecting it to be completed between sessions) is a routine component of BPT. Assignments for Session 1 often include asking parents to generate a list of house rules, targeting specific behaviors that they would like to see changed immediately. Sessions thereafter routinely begin with review of homework assignments. One of the key components of behavioral parenting interventions is practicing skills between sessions and monitoring the child's response to these new skills. For this reason, homework is an important component. When homework assignments are not completed by parents—especially repeatedly—it is essential for the therapist to take time to problem-solve obstacles to completing homework. Therapists should be flexible with meeting parents in the middle and compromising to encourage at least some practice time between sessions.

Sessions typically begin with didactic instruction on effective parenting and communication/problem-solving skills with parent couples, but then these evolve into discussions on how these skills can be tailored to meet the needs of the couple. Discussion ultimately leads to role plays between parents or between one clinician (acting like child) and one or more parents to practice effective skills use. *In vivo* practice of communication and problem-solving skills between parents, with the therapist working as a facilitator, is also a common approach. *In vivo* skills practice with the child present and interacting with the parents is also a good idea, particularly with young (3- to 8-year-old children) and parents who are having difficulty translating material discussed in session to effective use at home.

Decisions with regard to pacing session content, including knowing whether to adjust the focus of material to keep parents invested in treatment and to avoid attrition (e.g., front loading review of punishment techniques for severe misbehavior, such as time-out, for children with more challenging behavior), slowing transition from skill to skill to ensure parents are comfortable or attain mastery of important techniques before moving on, and breathing life into the delivery of parenting interventions, particularly for parents who have been through parenting courses before or for parents (often fathers) who are difficult to engage, are all up to the therapist's best judgment, informed by the unique needs of the family with whom they are working. Working with parents rearing children with chronic disruptive behavior, while also managing their own or their partner's mental health concerns, requires the therapist to be highly flexible and able to think quickly on their feet to adjust the course of care as needed. Of course, one should not repeatedly forego treatment plans to focus entirely on "the crisis of the week," but the therapist should be mindful that if the couple is showing subtle signs of resistance (e.g., canceling repeatedly without good reasons, asking to space out sessions, not doing homework, one parent stops coming), they should promote a discussion about unmet needs to better address the most challenging child behavior or couple relationship difficulties.

As part of this discussion, the clinician may need to find middle ground between parents who "agree to disagree" on how best to respond to disruptive child behavior. Not only does this inconsistency perpetuate disruptive child behavior, but it may also be associated with one or both parents being disengaged in therapy. In these situations, clinicians should strive to successfully "mediate" a resolution in which parents agree to work together to improve a few specific disruptive child behaviors, while tabling other behaviors on which they disagree regarding severity or need to address. The focus of the mediation discussion is to find common ground for the sake of their child, and not letting their broader relationship discord get in the way of alleviating their child's impairment. Additionally, the clinician may need to provide a clearer rationale for homework assignments and conduct a problem-solving discussion with the parents to potentially lower or remove obstacles to completing work between sessions (e.g., reducing frequency of assignments, building in rewards for parents completing assignments).

Components of BPT

BPT aims to increase appropriate, prosocial behaviors and decrease inappropriate, negative behaviors in children, especially those with patterns of disruptive or acting-out behavior, by increasing the agency and behavior management skills of their parents. BPT is typically delivered to parents individually with a therapist or in a group with five to 20 parents and a therapist in a clinic, community, or school setting, and commonly occurs over the course of four to 16 weekly meetings, each lasting 60–120 minutes. Face-to-face and virtual options exist. Content covered includes teaching about attention and behavior problems (i.e., providing psychoeducation about ADHD and related problems, such as ODD), as well as reviewing the connection between antecedents of behavior, consequences of behavior, and specific behavioral patterns. Parents then list major and minor misbehaviors, as well as behaviors of medium severity, in an effort to prioritize behavioral goals and targets. Once psychoeducation and goal-setting sessions are complete, weekly sessions focus on one or two behavior management skills or principles.

Behavior management skills and principles are reviewed through psychoeducation and skills building modules. Skills building modules often include introduction of new skills via viewing video of inappropriate behavior management skills, discussion of new behavior management skills, modeling of appropriate use of skills by therapist or parent, role play of appropriate use of skills with parent(s) and therapist, and planning ahead to apply skills in real-world situations the following week. Parents come prepared the following week to review success or difficulties in applying the newly learned skills. Skills may be taught didactically or via collaborative problem-solving methods (e.g., letting group of parents observe specific parenting behaviors exhibited in a video and allowing parents to brainstorm what was problematic in a parent's behavior, the consequences of the behavior, alternative strategies for the parent, and the likely effect the parent's use of the new behavior will have on the child and family overall).

Specific skills taught may include using specific labeled praise, incorporating special quality time, and positive attending for appropriate behavior; using planned ignoring of minor inappropriate behavior; giving effective commands, transitional warnings, and statements implying natural consequences (e.g., "When you complete this task, you can do what you want to do"); creating house rules; instituting time-out from positive reinforcement (i.e., "Time-out") for violations of house rules; establishing a daily report card (DRC) or daily list of goals for the home and school; building a reward program to celebrate varying levels of DRC success; creating an emotion regulation plan; working with the child's teacher and school to maximize home–school success; problem solving; and planning ahead to prevent or decrease future misbehavior. After these core skills are taught over a period of 1–4 months, booster sessions are often advised to ensure maintenance of gains in both parenting behavior and children's behavior.

Additional BPT enhancement sessions may be added at the beginning, to maximize engagement, or at the end, to better ensure maintenance of gains. Some BPT enhancement programs have included motivational interviewing for three sessions to manage parents' expectations for treatment, provide education about what to expect for children given developmental norms, and better understand how treatment might be tailored to fit parents' needs and philosophical beliefs. Some BPT enhancements include addition of unique and relatable psychoeducational sessions from one manualized BPT program, such as utilizing the "Best and Worst Supervisor" from Barkley's (2013) *Defiant Children*, to the beginning of another BPT program. Other BPT enhancements have included a longer taper or added extra sessions to troubleshoot behavioral management strategies that seem only partially effective.

Mechanisms of Change

BPT theory suggests that improvements in children's behavior come about as a direct result of changes in parenting behavior. Furthermore, evidence indicates that improvements in parenting behavior and reductions in parenting distress can improve interpartner relationship satisfaction, communication, and consistency, as well as improve the parent–child relationship, which can further enhance partners' satisfaction with each other (Erel & Burman, 1995). Research also suggests that improvements in parenting behavior accompany changes in parents' attributions and cognitions (Johnston, Mah, & Regambal, 2010). Additional research suggests that improvements in children's disruptive behavior could spill over to improve partner communication (Wymbs & Pelham, 2010) and reduce risk of their parents divorcing (Wymbs et al., 2008).

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

BPT has been developed for implementation with parents of children with behavioral problems broadly and is a well-established treatment for ADHD and CD/ODD according to the American Psychological Association Division 53 Task Force guidelines. BPT addresses children's behavior problems; the parent–child relationship; parenting behaviors; and, in some instances, disruptive child behavior outside the home (peer and school settings). BPT programs as a whole and as specific types have been evaluated for over 40 years and have been found to be effective in reducing children's ADHD and other disruptive symptoms across a number of studies (e.g., Sonuga-Barke, Daley, & Thompson, 2001; Thurston, 1979; Webster-Stratton, 1985). Studies evaluating BPT have consistently shown improved parent management skills and decreased behavioral problems in children, and these gains have been maintained over time (Webster-Stratton, 1985). BPT has been associated with longer-term improvements in ADHD and in other areas of functioning (e.g., Sonuga-Barke et al., 2001). Parents have reported that in addition to children's behavior improving, child adjustment has improved, and parents report feeling better able to manage their child's behavior following BPT (Webster-Stratton, 1985). For parents, BPT often improves couple relationship satisfaction and decreases relationship discord, as it aims to facilitate partner communication and parenting consistency between partners, as well as improve the child's behavior and reduce associated parenting strain.

Unfortunately, despite its empirical support, BPT is not associated with gains among all children and families, as it is associated with high dropout and limited access among some families from underserved populations. Although some parent programs have been studied extensively with families from underserved populations, such as those in poverty (e.g., Incredible Years Program; *https://incredibleyears.com*), recent meta-analytic research shows that parent training effectiveness trials have been conducted with mostly White and mostly middle-to-upper income families (Evans et al., 2018), which potentially limits generalizability to lower-income populations.

Additionally, few BPT interventions to date have included focus on the partner relationship, save for the Triple P program (Sanders, 2008), which includes modules focused on improving couple relationship quality and communication. Early evaluations of this program interweaving BPT and problem-solving skills for discordant couples rearing youth with disruptive behavior disorders produced significant gains in child behavior, as well as parenting and couple satisfaction when compared with discordant parent couples who received BPT only (Dadds, Schwartz, & Sanders, 1987).

Similarly, little is known regarding the efficacy of interventions for couples including adults with ADHD. It is clear that, owing to their symptoms, adults with ADHD benefit less from BPT interventions (Sonuga-Barke et al., 2002). As such, researchers have attempted to target adult ADHD symptoms with evidence-based pharmacotherapy prior to parenting interventions, but these efforts have yielded mixed results (e.g., Babinski, Waxmonsky, & Pelham, 2014). Emerging research in this area is attempting to better address ADHD in families with parents and children having this disorder.

To this end, Wymbs and Molina (2015) pilot-tested a therapy approach to treating adult ADHD integrating behavioral couple therapy principles with CBT for adult ADHD. This brief treatment (six 1.5-hour sessions) was delivered to couples including at least one adult with ADHD (most included two partners with ADHD) in a small-group format integrating communication and problem-solving skills alongside effective ADHD self-management strategies every session. Effect sizes indicated that individuals with elevated ADHD symptoms reported fewer symptoms of IA and HI following treatment, and participants with and without elevated ADHD symptoms indicated lower relationship impairment. Partner ratings corroborated some areas of improvement. This preliminary trial underscores the potential benefit of combining interventions for families affected by ADHD and suggests the promise of strengthening couple relationships as a mechanism for improvement in these families. However, as this study was conducted with adults who were not parents, evidence supporting this therapeutic approach with parents, particularly those with children exhibiting disruptive behavioral issues, remains an area of need.

CASE ILLUSTRATION

Eddie first presented to our ADHD Specialty Clinic when he was 5 years old and had longstanding and maladaptive IA, HI, aggression, and oppositionality. An only child, he was referred by his biological parents, Jane and Tim, who had been married for 15 years at the time of Eddie's referral. Over the preceding few months, Jane and Tim had become increasingly frustrated with Eddie's disruptive and noncompliant behavior, which included hitting his parents, (sometimes dangerously so (e.g., throwing a bottle at his mother while she was driving), being verbally abusive toward them, cursing, and refusing to do what he was asked despite repeated instructions and threats of losing privileges. Tim and Jane differed in their behaviors toward Eddie; whereas Tim was terse and abrupt with Eddie, Jane tended to give extra reminders regarding misbehavior. Jane also advocated extra attention or fun activities, thinking that these would facilitate better behavior; Tim, on the other hand, argued for "tough love," with Jane remarking that Tim took Eddie's behaviors too personally and escalated his behaviors to disruptive levels. Tim was interested in behavioral therapy for Eddie to help him manage his impulses and disruptive outbursts and hoped that this would include more discipline for negative behavior. Jane was interested in behavior therapy for Eddie to help her son not only to learn self-control but also to help her and Tim to become more consistent in their childrearing behaviors and to strengthen their intrafamilial relationships, including their marital relationship, which was perceived as having taken a turn for the worse since Eddie's behaviors had intensified.

Accordingly, the therapist took a two-pronged approach to this case: BPT to address Eddie's disruptive behaviors, and principles of behavioral couple therapy to strengthen Jane and Tim's relationship. The first three therapy sessions focused on parent training for the first half of each session and principles of behavioral couple therapy for the second half. Given the severity of Eddie's ongoing behavior, however, the next eight sessions focused exclusively on BPT. The final four sessions utilized select strategies from IBCT (see Chapter 4, in this volume, by Christensen et al.).

Session 1

The therapist began BPT by eliciting from Tim and Jane the following list of behavioral goals for Eddie: no physical aggression, talking back, breaking things, or cursing, as well as following directions the first time asked. To help the couple begin to critically think about their own behaviors and to begin building some unified goals, the therapist also asked Jane and Tim to recall their own best and worst supervisor from work or school experiences, and what behaviors these supervisors used. Jane and Tim both stated that their best supervisor was encouraging, gave credit when credit was due, and was cool, calm, and collected when things went wrong. Their worst supervisor was unpredictable, took credit for others' work, and was critical. Then the therapist asked the couple for whom they were more likely to go the extra mile, and they agreed that they would be more likely to do this for the best supervisor.

In the second half of the session, the therapist conducted a functional behavioral assessment (i.e., evaluating behaviors in the context of antecedents, triggers, and consequences) of an example of Eddie's disruptive behavior, provided by Jane, which aptly illustrated how her son's behaviors could drive a wedge between herself and Tim. The couple recalled how the previous weekend Eddie called Jane a "b----" and threw a videogame controller and television remote to the ground after being told to come on an errand, breaking the remote. Jane and Tim reflected that earlier that day, Eddie had said, "I can't wait to play games all afternoon! School is the worst!" Eddie had received his report card the Friday before; he had failed two classes, and his teacher had written that he was the "class clown" and "too talkative during class." Eddie had previously complained about school and his teacher, but the report card really upset him; he began crying whenever school was brought up afterward. Eddie had not had a snack and had a poor night's sleep before the incident, per Jane. According to Jane and Tim, after Eddie broke the remote, he tried to put it back together, amid tears. When the therapist asked, "What happened next?" (to solicit consequences), Tim noted that he "reprimanded Eddie" and said "Now look at what you have done! Your allowance will go toward a new remote! You can kiss $50 good-bye!" Eddie had been saving money for a new videogame, and he began to cry harder, per Tim. Tim stated that Eddie cursed at them both and acted like he was going to physically attack them. Tim held up his hands and said, "Do you want to fight?" Eddie responded, "Yes!" Jane indicated that she then began to cry, begged both Tim and Eddie to stop arguing, and screamed that she wished both of them could get along. Eddie yelled at them, cursed his father, and slammed the front door as he ran outside and allegedly ran around to cool down. Tim stayed inside, he said, and screamed into a pillow in their bedroom. When he felt calmer, he returned to the living room to check on Jane. Jane cried until Eddie returned home, and no one spoke of the incident again, until this session, 2 weeks later. Jane, Tim, and Eddie ate dinner in separate rooms and went to bed.

Jane and Tim said that this kind of interaction (i.e., Eddie having an outburst, Mom relenting, Dad becoming verbally combative, Eddie becoming more aggressive) was typical, and that Mom and Dad disagreed on how to handle it most of the time. Jane and Tim stated that just as they avoided discussing disagreements about handling Eddie's misbehavior, they largely avoided talking about their disagreements, in general. Jane and Tim both felt resentful toward their partner for "mishandling" the "Eddie situation," and also guilty for having such thoughts and related feelings. The therapist ended the first session by asking the couple to recount their first date. For homework, the therapist introduced the concept of engaging in caring behaviors and pleasurable activities/dates with one another and suggested that they go on a date in the upcoming week. The couple stated that they would engage in caring behaviors but could not find a time this week, but that they intended to go on a date the following week. The therapist agreed that this plan would suit.

Session 2

In the second session, the therapist found that Jane and Tim had begun engaging in caring behaviors and had gone on a date without prompting. The therapist introduced the concept of "house rules" and asked Jane and Tim to select one to two of Eddie's behaviors they regarded as major misbehaviors that would get him in trouble at school, home, or various places in the community. Homework included increasing caring behaviors, with a focus on noticing positive behaviors of each partner, going on one date, and informing Eddie of house rules in a conversation and in a visual posting on the refrigerator. Jane and Tim planned to give a consequence (i.e., sending Eddie to his room, which the family currently used as consequence) if Eddie broke a house rule.

Session 3

Jane and Tim reported that Eddie "reacted negatively" toward house rules in that he had tantrums when his parents introduced them and any time he was told he broke a house rule and was sent to his room; he escalated to worsening, more egregious behavior (e.g., pulling out all pots and pans from shelves in kitchen such that they made crashing sounds). This led Jane and Tim to additional disagreements and dissatisfaction with the week and the parent management techniques discussed in the previous session. The therapist provided empathy and validation and explained the concept of behavior worsening before improving (i.e., extinction burst) and that this often occurs when a new structure or expectation is in place. Jane and Tim did not go on a date but did engage in caring behaviors (e.g., Tim drew the bath for Jane and put air in Jane's tires, so that she could ride her bike around the neighborhood; Jane made Tim's favorite chicken on the grill and insisted they watch together Tim's favorite team play basketball on TV) and they each occasionally thanked each other person for those. The therapist introduced active listening to Jane and Tim, as well as the techniques of specific, labeled praise (e.g., “Eddie, way to organize your gear for soccer practice!”) and special quality time (i.e., spending uninterrupted time with Eddie in which he chooses the activity for 15 minutes and parents avoid asking him questions or making requests) for Jane and Tim to try with Eddie. Homework included practicing active listening strategies once or twice during the first day of the week when Eddie is behaving appropriately and before he is engaged in misbehavior. The couple was instructed to “use the floor” if needed. If Eddie’s behavior escalated or he exhibited major misbehavior, Jane and Tim were instructed to discuss how things went after Eddie exhibited the misbehavior and was behaving appropriately in a private setting (e.g., parents’ bedroom after Eddie went to bed). Homework also included informing Eddie that he would get special playtime for 5–15 minutes every night; Jane and Tim agreed to engage in special playtime every night. Jane and Tim also agreed to homework that involved giving three instances of specific, labeled praise for every instance of Eddie’s misbehavior.

Sessions 4–11

Given Eddie’s response and his parents’ additional upset regarding his continued oppositionality, it was deemed necessary to shift to a primary focus on BPT; that is, the need to address the disruptive child behavior seemed acute, as it was clearly the underlying reason for the couple’s relationship strain, and if more resources were not devoted to doing so, there was a real possibility of the parents discontinuing services. This portion of the overall intervention was accordingly aimed at increasing Eddie’s appropriate behavior and decreasing his negative behavior through a variety of reinforcement and discipline strategies. Session content was adapted from the Defiant Children program (Barkley, 2013), the Community Parenting Education (COPE) program (Cunningham et al., 2006), and the Explosive Child approach (Greene, 2014). Each session included (1) review of the previous week’s topic and home-based practice, (2) presentation of a new topic and discussion of how it would be implemented, (3) role play of the new skills, and (4) assignment of out-of-session practice. Jane attended every session and Tim attended every fourth session (i.e., monthly) given his work schedule. Often, Jane and Tim reported differences in implementing the new skills and varying effectiveness, though, over time, they began to show more consistency in both their reported use and success. Session topics focused on planned ignoring; giving effective commands and transitional warnings/when–then statements; using time-out; creating and applying a privilege program; establishing a daily list of goals (or DRC) at home and school; planning ahead for misbehavior outside the home; problem solving; and creating an emotion regulation plan.

One noteworthy event occurring near the end of this therapy phase. While Jane was out of the room, Eddie protested when Tim appropriately withheld Eddie’s dessert as part of a privilege program. Tim reported to the therapist in session that Eddie’s explosive reaction (i.e., yelling and insulting) triggered him, causing him to yell and threaten to ground Eddie for the rest of the school year, instead of straightforwardly informing Eddie that he earned a time-out for not meeting the expectation of respecting his parent. Eddie ran to the garage, grabbed garden shears, and returned, threatening his father with them. Although Eddie did not attack, Tim called 911, and Eddie rode via ambulance to the hospital, where he eventually was admitted to the inpatient psychiatric unit for a 4-day stay due to “homicidal ideation.” Jane reported to the therapist that she felt guilty that she was not in the room when the altercation began and frustrated with her husband for escalating the situation. At this point, Jane and Tim began working with the therapist on an emotion regulation plan and began working intensively on couple therapy objectives.

Sessions 12–15

Owing to the strain in the relationship between Jane and Tim, the final four sessions focused on select strategies from IBCT. Specifically, the therapist reviewed acceptance strategies, including acceptance through empathic joining, tolerance strategies, including tolerance building, and change strategies, including increasing positive behaviors in an effort to decrease resentment and frustration between partners for engaging in annoying behaviors (e.g., grinding teeth, withdrawal, “permissive parenting,” or “militant parenting”), encouraged behavioral change for ineffective co-parenting or communication strategies (e.g., yelling or taking over), and strengthening the relationship by engaging in a care behavior or a pleasurable activity.

In the final stage of therapy, the therapist focused on acceptance through empathic joining. In the previous session on emotion regulation, Jane had stated that she felt sadness for Eddie, as he had a difficult time managing his emotions, especially anger. Tim took this perspective as Jane "siding with Eddie" and excusing his behavior.

TIM: I don't get it. You always take his side. He is the one that threatened me with the garden shears and now you feel sorry for him and believe I was in the wrong.

JANE: I did not take his side and I am not taking his side. I just feel pain and sadness for him as he has a difficult time keeping his anger in check.

TIM: Well, he needs to be accountable for his reactions and behavior. I was threatened in this situation, and he was out of control. He could have been sent to juvenile detention.

JANE: I don't want him there. He doesn't belong there. He is a sweet boy who gets out of control.

TIM: See, there you go again . . .

THERAPIST: Hold on a second, Tim. I might be wrong, but what I am hearing you say, Jane, is not that you think Eddie was right and Tim was wrong or that Eddie should not be held accountable for his behavior, but rather that you are sad that he has such difficulties with emotion regulation. [The therapist is trying to elicit a softer response from Jane and Tim, hoping that Jane's ability to feel and sit with sadness will encourage Tim to feel Jane's sadness and be less angry.]

TIM: I know that things are difficult for Eddie and therefore difficult for you to watch, Jane.

THERAPIST: (*to Tim*) I want to make sure that you are really hearing what Jane is saying. You are getting angry because you think that she is choosing Eddie over you or letting him off the hook, but in fact, she is holding him accountable and feeling sad. I think that she wants you to feel sadness with her and understand that she feels sad. Do I have that right, Jane?

JANE: Yes.

TIM: I do see that you feel for Eddie, Jane. And I see that you feel sad. What can I do?

JANE: I would like you to just sit with me when I'm feeling sad and not judge me for feeling sad and not ask me not to be sad or try to fix it. Just understand that I am feeling sad and be okay with me being sad.

TIM: I can do that.

In the next session, the couple worked on building tolerance. One of the patterns that contributed to distress for Tim and Jane was a pattern of Tim raising his voice and arguing when Eddie acted out and Jane withdrawing emotionally and physically from the situation. This pattern had been long-standing; in fact, similar behavior patterns were even noted in Tim and Jane's families of origin. The pattern was troublesome to both of them. The therapist decided to ask the couple to fake the negative behavior to build tolerance. The thinking was that faking the negative behavior would allow Tim and Jane to become less distressed over time, as each would become desensitized to the behavior when they saw it.

THERAPIST: Tim, show me how you raise your voice when Eddie starts to misbehave. I want to see the intensity of your reaction, as well as the type of words you use in an argument and the emotion with which you say them.

TIM: (raising his voice) Eddie, throw the remote like that one more time and you're going to your room for the rest of the night without dinner. And paying for the remote!

THERAPIST: Jane, I want to know if the way that Tim is raising his voice is consistent with how he does at home.

JANE: Okay. Well, so far, he is being much less intense than he is at home.

TIM: (*raising his voice further, threatening, grinding his teeth*) Eddie, don't talk back to me! Do as you're told! Oh yeah, you want to talk like that to your old man? Try it and see where it gets you, and by the way, the answer is "no" to going to the ball fields tomorrow.

JANE: That's more like it.

Jane then discussed her predilection to retreat inward and shut down. Jane said that she started to withdraw in the session, and Tim said that this was upsetting to hear. Jane added that the teeth grinding was most off-putting but the yelling was intolerable to her, too. At this point, the therapist paused because Tim's intense reaction (e.g., grinding teeth) might be something that Jane could learn to tolerate, but the punitive and threatening parenting behaviors were ultimately ill-advised for the BPT model. The therapist affirmed both Tim and Jane for identifying the reaction that was most upsetting to them. This in-session experience is an example of tolerance building, and it also fostered empathic joining, as they each learned the impact their behavior had on each other. The therapist suggested the "faking negative behavior" exercise to the couple in an effort to desensitize Tim and Jane to their respective unpleasant behaviors (e.g., Tim: fake grinding his teeth; Jane: fake withdrawing) over the course of the next week. The therapist also worked with Tim to give neutral feedback (e.g., not raising his voice, avoiding antagonistic comments, and showing no signs of annoyance when giving a verbal correction) to Eddie when he was engaging in targeted, inappropriate behavior.

The next week, the couple reported that they had each engaged in faking the negative behavior, and Tim said that he was less distressed when Jane faked withdrawal. Jane said that she was still irritated with Tim when he ground his teeth, and became more frustrated when he yelled at Eddie, but she said that she was a bit less distressed. Tim said that he would work to reduce his yelling. Jane said that she would try to get used to teeth grinding. Over the final weeks with the therapist, Jane reported being less bothered by Tim's teeth grinding, and Tim and Jane reported that Tim had reduced his yelling and arguing.

In the last two sessions, the therapist encouraged Jane and Tim to use behavior exchange (BE) techniques. Tim was agreeable to helping with chores, and Jane was agreeable to going on a date. Over the course of the next 2 weeks, Jane and Tim reported that they engaged in BE twice, and that going on a date was so much fun that they wanted to do it weekly—a positive step to rebuilding a positive relationship. Jane reported that the babysitter and Eddie got along well, and that she felt comfortable making this a weekly activity. Jane also said that she had fun on the dates, especially knowing that the housework was done (Tim had helped) beforehand and she did not have to return to a messy home. Tim reported that he felt less stressed when he knew he had coveted time with his wife. Both partners reported that their satisfaction with one another increased greatly once BE was implemented.

Follow-Up

In total, Jane and/or Tim attended 18 sessions of therapy, with some traditional behavioral couple therapy skills sprinkled throughout initial BPT sessions, eight that focused exclusively on BPT, and five that included IBCT. Posttreatment, both Jane and Tim anecdotally reported increased understanding of one another, improved child-rearing practices, better communication, and improved couple relationship satisfaction.

Unfortunately, even this combined therapy did not fix all of their problems. Eddie continued to have occasional severe behavioral outbursts, requiring two brief residential treatments owing to aggressive behavior that endangered others' safety. Jane and Tim continued to have different parenting values and practices, with Jane showing a predilection toward giving Eddie extra chances and remaining neutral and unfazed when Eddie acted out toward her or Tim, and Tim showing an authoritarian style of parenting, demanding that something be done because "I told you so." Jane and Tim reported that, albeit less often, they continued to sometimes fall into the pattern of Tim grinding his teeth and relentlessly arguing, and Jane shutting down. However, at the end of therapy, both partners reported that they felt like they were "on the same page" more often than not and could see the perspective of their partner.

The therapist applied a range of IBCT interventions (acceptance via empathic joining, tolerance via faking negative behavior, and change behaviors via behavioral exchange) with Jane and Tim. Empathic joining helped to build understanding for the reasons behind Tim's frustration and Jane's withdrawal. Tolerance helped to desensitize Jane to Tim's teeth grinding and Tim to Jane's withdrawal. Exchange behaviors (EBs) served as natural consequences and became self-reinforcing as both Jane and Tim reported enjoying date nights immensely, and EBs were more productive than simply agreeing on one pleasurable activity together because Jane could not relax until some of her responsibilities were taken off her plate.

Overall, this family benefited immediately and over time from a therapy that combined aspects of BPT and IBCT. Objective measures of relationship satisfaction showed, posttreatment, both Jane and Tim to have made reliable change, moving into the nondistressed range. Jane showed reliable change on effective parenting measures as well, scoring in the normative range; although Tim did not show reliable change in parenting at posttreatment, he improved over time and was in the nondistressed range 1, 2, and 3 years' posttreatment. Eddie continued to have severe behavior problems at posttreatment per both Jane and Tim (verbally and objectively), but subsequent 1-, 2-, and 3-year follow-up suggested improvements in severely disruptive behavior (e.g., physical aggression, destruction of property) and ADHD.

CONCLUDING COMMENTS

ADHD, a commonly diagnosed disorder originating in childhood, is associated with HI, IA, and related disruptive behaviors that are likely to strain relationships in the family system. This is particularly so in cases involving comorbidity of other clinically meaningful behavioral disorders (e.g., ODD, CD), as this particularly amplifies the frequency of emotionally charged parent–child interactions that call for not only an understanding of the underlying issues but also corrective parenting, both things on which a couple may disagree. Such disagreements could be exacerbated by the very nature of ADHD, in that hereditary risk factors present in the child are fairly likely to manifest in one or both parents, and social dysfunction, including couple relational problems and dissolution, are common issues for adults with ADHD.

While there is scant published literature on treatments that directly address couples' issues associated with child behavior problems, it is clear from research on BPT, an empirically supported psychotherapy for children with ADHD, that the cooperation of custodial parents is a critical aspect of success. The integration of couple therapy into a BPT approach, including facilitating perspective taking, reestablishing positive relational behaviors, effective communication and problem solving, as well as child-specific agreements on behavioral goals and means to achieve those ends, can not only help to maximize the chances of success at addressing or mediating the impact of the child's disorder but also strengthen the couple's relationship. Given the relatively high prevalence of ADHD in children, therapists who work with couples are encouraged to become familiar with BPT and to consider how couple therapy techniques can be integrated (and vice versa) to best serve the needs of the entire family.

The development and evaluation of intervention protocols that provide a formalized structure for treating couple distress of this specific nature—and those in which child behavior problems stem from other disorders as well—remains a goal for the future. In the meantime, we encourage therapists to document their handling of such cases and the subsequent outcomes, and to disseminate reports in the literature and elsewhere. Such endeavors are crucial to guide the field forward through this ill-charted territory and, ultimately, to best serve this population.

SUGGESTIONS FOR FURTHER STUDY

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York: Guilford Press.

Greene, R. W. (2014). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children.* New York: HarperCollins.

Incredible Years: https://incredibleyears.com

McMahon, R. J., & Forehand, R. L. (2005). *Helping the noncompliant child* (2nd ed.). New York: Guilford Press.

Safren, S. A., Sprich, S. E., Perlman, C. A., & Otto, M. W. (2017). *Mastering your adult ADHD: A cognitive-behavioral treatment program, therapist guide* (2nd ed.). New York: Oxford University Press.

REFERENCES

Abidin, R. R. (2012). *Parenting stress index* (4th ed.). Lutz, FL: Psychological Assessment Resources.

Achenbach, T. M. (2009). *The Achenbach System of Empirically Based Assessment (ASEBA): Development, findings, theory, and applications.* Burlington: University of Vermont Research Center for Children, Youth, and Families.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Babinski, D. E., Waxmonsky, J. G., & Pelham, W. E. (2014). Treating parents with attention-deficit/hyperactivity disorder: The effects of behavioral parent training and acute stimulant medication treatment on parent–child interactions. *Journal of Abnormal Child Psychology, 42,* 1129–1140.

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York: Guilford Press.

Barkley, R. A. (Ed.). (2015). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (4th ed.). New York: Guilford Press.

Barkley, R. A., Murphy, K. R., & Fischer, M. (2008). *ADHD in adults: What the science says.* New York: Guilford Press.

Camparo, L. B., Christensen, A., Buhrmester, D., & Hinshaw, S. (1994). System functioning in families with ADHD and non-ADHD sons. *Personal Relationships, 1,* 301–308.

Canu, W. H., Tabor, L. S., Michael, K. D., Bazzini, D. G., & Elmore, A. L. (2014). Young adult romantic couples' conflict resolution and satisfaction varies with partner's attention–deficit/hyperactivity disorder type. *Journal of Marital and Family Therapy, 40,* 509–524.

Chronis, A. M., Lahey, B. B., Pelham, W. E., Kipp, H. L., Baumann, B. L., & Lee, S. S. (2003). Psychopathology and substance abuse in parents of young children with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 1424–1432.

Cowan, P. A., & Cowan, C. P. (2003). Normative family transitions, normal family processes, and healthy child development. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (pp. 424–459). New York: Guilford Press.

Cunningham, C. E., Bremner, R., & Second, M. (2006). *The Community Parent Education Pro-*

gram: A school-based, family-systems-oriented workshop for parents of children with disruptive behavior disorders. Hamilton, ON, Canada: COPE Works.

Dadds, M. R., Schwartz, S., & Sanders, M. R. (1987). Marital discord and treatment outcome in behavioral treatment of child conduct disorders. *Journal of Consulting and Clinical Psychology, 55,* 396–403.

Deault, L. C. (2010). A systematic review of parenting in relation to the development of comorbidities and functional impairment in children with attention-deficit/hyperactivity disorder (ADHD). *Child Psychiatry and Human Development, 41,* 168–192.

dosReis, S., Barksdale, C. L., Sherman, A., Maloney, K., & Charach, A. (2010). Stigmatizing experiences of parents of children with a new diagnosis of ADHD. *Psychiatric Services, 61,* 811–816.

DuPaul, G. J., Power, T. J., Anastopoulos, A. D., & Reid, R. (2016). *ADHD Rating Scale–5 for children and adolescents: Checklists, norms, and clinical interpretation.* New York: Guilford Press.

Eakin, L., Minde, K., Hechtman, L., Ochs, E., Krane, E., Bouffard, R., & Looper, K. (2004). The marital and family function of adults with ADHD and their spouses. *Journal of Attention Disorders, 8,* 1–10.

Erel, O., & Burman, B. (1995). Interrelatedness of marital relations and parent–child relations: A meta-analytic review. *Psychological Bulletin, 118,* 108–132.

Evans, S. W., Langberg, J. M., Schultz, B. K., Vaughn, A., Altaye, M., Marshall, S. A., & Zoromski, A. K. (2016). Evaluation of a school-based treatment program for young adolescents with ADHD. *Journal of Consulting and Clinical Psychology, 84,* 15–30.

Evans, S. W., Owens, J. S., Wymbs, B. T., & Ray, A. R. (2018). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Clinical Child and Adolescent Psychology, 47,* 157–198.

Fabiano , G. A., Pelham, W. E., Waschbusch, D. A., Gnagy, E. M., Lahey, B. B., Chronis, A. M., . . . Burrows-MacLean, L. (2006). A practical measure of impairment: Psychometric properties of the impairment rating scale in samples of children with attention deficit hyperactivity disorder and two school-based samples. *Journal of Clinical Child and Adolescent Psychology, 35,* 369–385.

Faraone, S. V., & Larsson, H. (2019). Genetics of attention deficit hyperactivity disorder. *Molecular Psychiatry, 24, 562–575.*

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Child Psychology and Psychiatry and Allied Disciplines, 38,* 581–586.

Greene, R. W. (2014). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children.* New York: HarperCollins.

Johnston, C., & Chronis-Tuscano, A. (2015). Families and ADHD. In R. A. Barkley (Ed.), *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (pp. 191–209). New York: Guilford Press.

Johnston, C., Mah, J., & Regambal, M. (2010). Parenting cognitions and treatment beliefs as predictors of experience using behavioral parenting strategies in families of children with attention-deficit/hyperactivity disorder. *Behavior Therapy, 41,* 491–504.

Jouriles, E. N., Murphy, C. M., Farris, A. M., Smith, D. A., Richters, J. E., & Waters, E. (1991). Marital adjustment, parental disagreements about child rearing, and behavior problems in boys: Increasing the specificity of the marital assessment. *Child Development, 62,* 1424–1433.

Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., . . . Walters, E. E. (2005). The World Health Organization Adult ADHD Self-Report Scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine, 35,* 245–256.

Knouse, L. E., Bagwell, C. L., Barkley, R. A., & Murphy, K. R. (2005). Accuracy of self-evaluation in adults with ADHD: Evidence from a driving study. *Journal of Attention Disorders, 8,* 221–234.

Kooij, J., Bijlenga, D., Salerno, L., Jaeschke, R., Bitter, I., Balázs, J., . . . Asherson, P. (2019). Updated European consensus statement on diagnosis and treatment of adult ADHD. *European Psychiatry*, *56,* 14–34.

Mikami, A. Y., Chong, G. K., Saporito, J. M., & Jiwon Na, J. (2015). Implications of parental affiliate stigma in families of children with ADHD. *Journal of Clinical Child and Adolescent Psychology, 44,* 595–603.

Murphy, K. R., & Barkley, R. A. (1996). Parents of children with attention-deficit/hyperactivity disorder: Psychological and attentional impairment. *American Journal of Orthopsychiatry, 66,* 93–102.

Ohan, J. L., Leung, D. W., & Johnston, C. (2000). The Parenting Sense of Competence scale: Evidence of a stable factor structure and validity. *Canadian Journal of Behavioural Science, 32,* 251–261.

Owens, J. S., Goldfine, M. E., Evangelista, N. M., Hoza, B., & Kaiser, N. (2007). A critical review of self-perceptions and the positive illusory bias in children with ADHD. *Clinical Child and Family Psychology Review, 10,* 335–351.

Pelham, W. E., Fabiano, G. A., & Massetti, G. M. (2005). Evidence-based assessment of attention deficit hyperactivity disorder in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 34,* 449–476.

Pelham, W. E., Gnagy, E. M., Greenslade, K. E., & Milich, R. (1992). Teacher ratings of DSM-III-R symptoms for the disruptive behavior disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 210–218.

Porter, B., & O'Leary, K. D. (1980). Marital discord and childhood behavior problems. *Journal of Abnormal Child Psychology, 8,* 287–295.

Ramsay, J. R. (2010). CBT for adult ADHD: Adaptations and hypothesized mechanisms of change. *Journal of Cognitive Psychotherapy, 24,* 37–45.

Reinert, D. F., & Allen, J. P. (2007). The Alcohol Use Disorders Identification Test: An update of research findings. *Alcoholism: Clinical and Experimental Research, 31,* 185–199.

Robin, A. L., & Foster, S. L. (1989). *Negotiating parent–adolescent conflict: A behavioral–family systems approach.* New York: Guilford Press.

Robin, A., & Payson, E. (2002). The impact of ADHD on marriage. *ADHD Report, 10*, 9–13.

Safren, S. A., Sprich, S. E., Perlman, C. A., & Otto, M. W. (2017). *Mastering your adult ADHD: A cognitive-behavioral treatment program, therapist guide* (2nd ed.). New York: Oxford University Press.

Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22,* 506–517.

Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. *American Journal of Psychiatry, 171,* 276–293.

Sonuga-Barke, E. J. S., Daley, D., & Thompson, M. (2002). Does maternal ADHD reduce the effectiveness of parent training for preschool children's ADHD? *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 696–702.

Sonuga-Barke, E. J. S., Daley, D., Thompson, M., Laver-Bradbury, C., & Weeks, A. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 402–408.

Speerforck, S., Stolzenburg, S., Hertel, J., Grabe, H. J., Strauß, M., Carta, M. G., . . . Schomerus, G. (2019). ADHD, stigma and continuum beliefs: A population survey on public attitudes towards children and adults with attention deficit hyperactivity disorder. *Psychiatry Research, 282,* Article 112570.

Steele, C. M., Wymbs, B. T., & Capps, R. E. (2020). Birds of a feather: An examination of ADHD symptoms and associated concerns in partners of adults with ADHD. *Journal of Attention Disorders.* [Epub ahead of print]

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283–316.

Thurston, L. P. (1979). Comparison of the effects of parent training and of Ritalin in treating hyperactive children. *International Journal of Mental Health, 8,* 121–128.

Ustun, B., Adler, L. A., Rudin, C., Faraone, S. V., Spencer, T., Berglund, P., . . . Kessler, R. C. (2017). The World Health Organization adult attention-deficit/hyperactivity disorder self-report screening scale for DSM-5. *JAMA Psychiatry, 74,* 520–526.

Webster-Stratton, C. (1985). Predictors of treatment outcome in parent training for conduct disordered children. *Behavior Therapy, 16,* 223–243.

Weikard, M. A. (1775). Drittes hauptstück mangel der aufmerksamkeit attentio volubilis. In *Der philosophische artzt* (pp. 114–119). Frankfurt: Zmenter Band.

Weiss, M. D. (2000). *Weiss Functional Impairment Rating Scale (WFIRS) self-report.* Vancouver: University of British Columbia.

Whalen, C. K., Henker, B., Ishikawa, S. S., Jamner, L. D., Floro, J. N., Johnston, J. A., & Swindle, R. (2006). An electronic diary study of contextual triggers and ADHD: Get ready, get set, get mad. *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 166–174.

Wymbs, B. T., Dawson, A. E., Egan, T. E., & Sacchetti, G. M. (2019). Rates of intimate partner violence perpetration and victimization among adults with ADHD. *Journal of Attention Disorders, 23,* 949–958.

Wymbs, B. T., Dawson, A. E., Egan, T. E., Sacchetti, G. M., Tams, S. T., & Wymbs, F. A. (2017). ADHD and depression symptoms in parent couples predicts response to child ADHD and ODD behavior. *Journal of Abnormal Child Psychology, 45,* 471–484.

Wymbs, B. T., & Molina, B. S. G. (2015). Integrative couples group treatment for emerging adults with ADHD symptoms. *Cognitive and Behavioral Practice, 22,* 161–171.

Wymbs, B. T., & Pelham, W. E. (2010). Child effects on communication between parents of youth with and without ADHD. *Journal of Abnormal Psychology, 119,* 366–375.

Wymbs, B. T., Pelham, W. E., Molina, B. G., Gnagy, E. M., Wilson, T. K., & Greenhouse, J. B. (2008). Predictors of divorce among parents of youth with ADHD. *Journal of Consulting and Clinical Psychology, 76,* 735–744.

Zisser, A., & Eyberg, S. M. (2010). Parent–child interaction therapy and the treatment of disruptive behavior disorders. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 179–193). New York: Guilford Press.

CHAPTER 28

Couple Therapy and Medical Issues

Nancy Breen Ruddy and Susan H. McDaniel

BACKGROUND

Medicine, like psychotherapy, has always been a hybrid of science and art. Time and training constraints can restrict the focus of health care professionals to only biological aspects of a patient's illness experience. Beginning in the last quarter of the 20th century, many health professionals (especially those in primary care) shifted toward integrating psychosocial facets of disease, with the *biopsychosocial approach* as the "gold standard" of care (Engel, 1977; see Figure 28.1). The biopsychosocial approach emphasizes the interrelatedness of biological, psychosocial, and community factors in health and disease, recognizing how health care intervention affects many levels of human experience. This shift has facilitated two major movements toward helping couples cope with medical problems.

The first movement has been toward a broader recognition of the role families play in health and illness. Many in the discipline of family medicine treat the family as the unit of care rather than the individual or an organ system (Doherty & Baird, 1983), acknowledging the reciprocal effects of family relationships, health, and disease. Family physician Jack Medalie (1994) first described the importance of a family approach in his account of missing the serious suffering of a spouse ("the hidden patient") while focusing on her husband after his heart attack. Family medicine clinicians are trained to integrate family systems thinking into day-to-day health care by including fathers or partners in prenatal care, spouses/partners or adult children in geriatric care, parents in adolescent care, and so forth (Carek et al., 2017). When the family is the center of health care, communication and other issues become the purview of medical professionals. Family medicine has been particularly welcoming to collaboration with family therapists, creating an inroad to treating couples and families in the medical setting. Family therapists in medical settings have a "frontline" view of how couples cope with illness, and how psychotherapy can help couples face the challenges of illness (Rolland, 2018).

Over the last two decades, the integration of behavioral health services into primary care settings has become more normative in academic and federally qualified health centers, along with broad-based implementation into the Department of Defense (Hunter, Goodie, Dobmeyer, & Dorrance, 2014) and in the Veterans Administration (Kearney, Post, Pomerantz, & Ziess, 2014). With varied success, multiple projects have worked to implement integrated behavioral health services into federally qualified health centers (Biel, Feinberg, Patel, & Romaire, 2019). This shift toward onsite mental health services has helped to focus care on psychosocial and relational elements (McDaniel, Doherty, & Hepworth, 2014; Ruddy, Borresen, & Gunn, 2008).

The second major movement has been the growth of interdisciplinary clinics that specialize in treating specific diseases. Many specialty clinics for chronic illnesses such as cystic fibrosis, cancer, and diabetes offer family-oriented

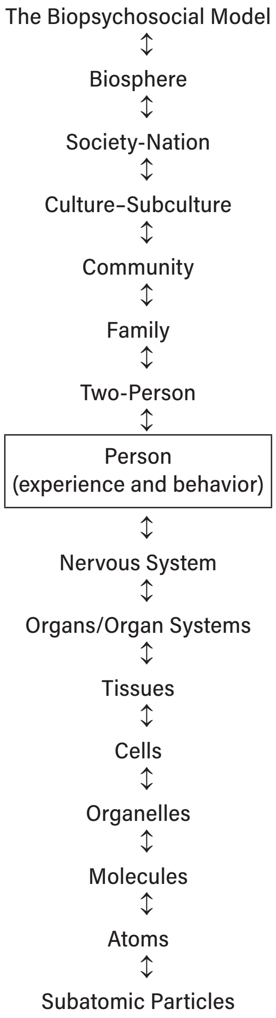


FIGURE 28.1. The biopsychosocial model.

services and recognize the importance of couple and family factors. They serve as "specialty medical homes" for people with chronic and serious health conditions. In many specialty clinics, embedded mental health professionals work in collaboration with other health care professionals to identify those in need and to provide support and treatment. This support provides resources for medical professionals when they recognize a couple or family struggling to cope with the stresses of a chronic illness. Early research shows promise in this attention to mental/behavioral health issues, reducing overuse of emergency services and improving patient outcomes, both physically and emotionally (Click & Regueiro, 2019).

Couple and family therapists, with their systemic lens, bring specific competencies to enhancing both clinical care and team-based functioning (DeCaporale-Ryan & Devine, 2019).

Finally, behavioral medicine has evolved further within pain management clinics that specialize. In the context of the opioid crisis, the role of behavioral management of pain is now central to pain management guidelines (National Institutes of Health, 2020).

Noting the impact of behavioral interventions on physical symptoms has lent further credence to the idea that mind and body are not only inextricably interconnected, but both are also necessary elements to healing. Family medicine practices and specialty clinics have created rich environments for the development of theory and techniques specifically designed for couples and families facing illness. In 1992, McDaniel, Hepworth, and Doherty published *Medical Family Therapy*, describing how couples and families often react and ultimately cope with illness, and how therapists can help them through this process (a second edition by McDaniel, Doherty, & Hepworth was published in 2014). In 1994, John Rolland published *Families, Illness, and Disability*, describing common patterns of couple and family coping with different types of illnesses and health situations. Rolland updated this work in 2018 with an expanded focus on integrated care entitled *Helping Couples and Families Navigate Illness and Disability: An Integrated Approach*. These books provided a foundation for psychotherapists working with couples and families facing illness; many books and articles have since been added to this literature.

THE HEALTHY VERSUS DISTRESSED COUPLE RELATIONSHIP

Minorities and people living in poverty are more likely to suffer from chronic illnesses (National Center for Health Statistics, 2016) and to have worse outcomes (Tai, Shah, Doubeni, Sia, & Wieland, 2021). Over the last decade research has established a relationship between individual and family trauma and health outcomes (Vig, Paluszek, & Asmundsen, 2020) and trauma's effect on the impact of health disparity reduction programs (Boparai et al., 2018). Yet, ill health knows no socioeconomic or racial bounds. Even highly resourced families with access to excellent health care struggle to cope with serious illness. Illness strikes everyone—both well-functioning and struggling couples. Rolland's "psychosocial illness typology" describes how different aspects of the illness itself put different types of demands on couples and families. Rolland (2018) integrated additional factors into the family systems illness model, outlining the evolution and systemic interaction of three dimensions: the psychosocial typology of illness, time phases within the illness experience, and elements of a given family's systemic functioning, both before and during the illness.

The couple's experience and response to a medical condition occurs in a "psychosocial developmental" process. Illness characteristics (onset, course, outcome, and functional impact) and the systemic makeup coalesce into different challenges and tasks the couples and family must navigate. The family's normative developmental tasks also affect, and are affected by, the intrusion of an illness. For example, a 16-year-old teenager may struggle to manage her diabetes while beginning to separate from her parents, who tell her to watch her diet and take her medication. This rebellion can then stress the parents' marriage. The life cycle stage into which the illness intrudes greatly determines which developmental tasks are likely to be disrupted. Yet therapists must not make absolute assumptions about the role of development, but rather should ask questions to reveal its impact, in recognition of variability across family structures, ethnicities, and so forth.

Rolland (2018) also notes that the couple's and family's tasks change over the course of the illness, with "crisis," "chronic," and "terminal" phases, each with its own challenges and tasks. Some illnesses challenge couples with an unpredictable course with starkly different "good days" and "bad days." In other cases, an illness starts as an acute episode that everyone expects to "go away," and only over time is it clear that the illness is chronic and lives may be forever changed.

Rolland (2018) notes that the interplay of illness phases and types form a "expanded system comprised of four interlocking triangles" (p. 51). The patient is in the middle of the system, surrounded by the partner, family, health care team, and the illness itself as a "fourth member of the system, having a personality (based on the patterns of onset, course, outcome, disability and predictability), and a developmental life course (the illness time phases)" (p. 51). A couple therapist must understand and address these intersecting factors to help couples successfully navigate a medical condition over time (see Figure 28.2).

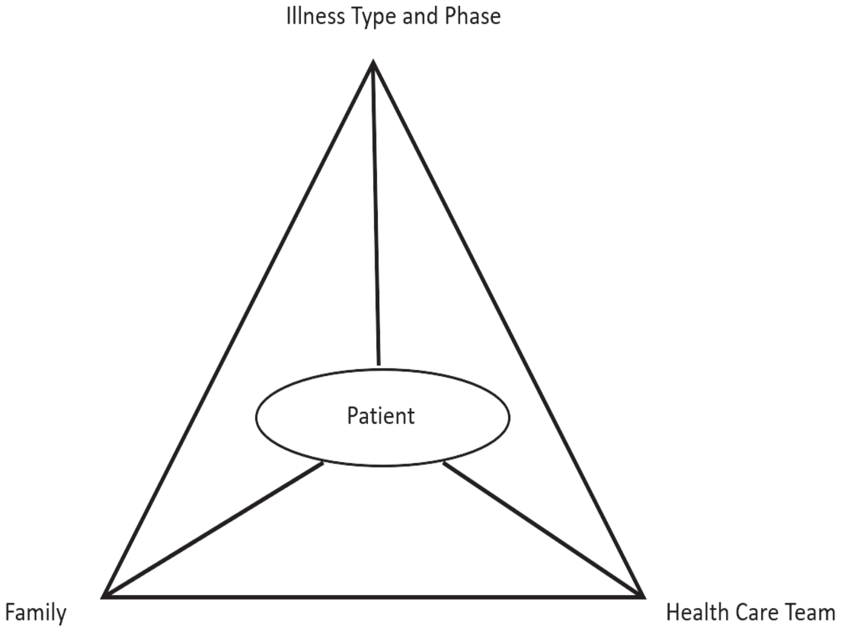


FIGURE 28.2. The family systems illness model. From Rolland (2018). Copyright © 2018 The Guilford Press. Reprinted by permission.

Case Illustration

Parkinson's disease struck Gregory when he was in late middle age. This coincided with "empty nest" for Gregory and Anna, who had planned to "live life" after their children went to college. Gregory and Anna sought therapy during the late chronic/terminal phase of the illness. Gregory and Anna must cope with a high degree of uncertainty as they live with Parkinson's.

Gregory was diagnosed with Parkinson's disease after some of his medical colleagues asked the family whether he had Parkinson's. Gregory and Anna always had been dedicated to each other throughout his active career and raising five children. As Gregory's illness resulted in his slow deterioration, Anna cared for his every need. Their children and Gregory's fellow health care professionals suggested in-home care and respite, but Anna would allow it only when Gregory became psychotic and combative at night. When he improved, she would discharge the outside help. "I don't like strangers in my house," she said. Gregory agreed and did not like Anna to be out of his sight. As the years went by and Gregory's functioning worsened, Anna became more and more fatigued, and their children began to worry about her health. During one confrontation with their physician, Anna admitted that for her, accepting outside help meant that Gregory was doing worse and would soon have to go to a nursing home and die. The longer she could do without help, she thought, the longer he would be with her.

Gregory and Anna were struggling to adjust to a new phase in Gregory's illness. They were largely unable to communicate about the deterioration in Gregory's functioning, as they sought to protect themselves and each other from a depressing truth. Gregory and Anna's difficulties accepting outside help from family and professional caregivers reflected not only their staunch independence and care for one another but also difficulties in accepting the impact of the illness. As can happen as couples adjust to changing illness demands, the initial "solution" to Gregory's caregiving needs—Anna as the primary and usually sole caregiver—began to unravel. The therapist worked to help them "hope for the best, prepare for the worst," redefining Anna's role in a way that also respected their desires for independence and privacy.

Research supports Rolland's theory that illnesses have specific elements that differentially challenge couples. Dalteg, Benzein, Fridlund, and Malm (2011) found five disease-specific themes that couples coping with cardiac disease experience: overprotection, communication deficiency, sexual concerns, changes in domestic roles, and adjustment to illness. Some of these challenges transcend many illness adaptations, with some particularly salient, such as sexual concerns in cardiac disease. Ek, Ternestedt, Andershed, and Sahlberg-Blom (2011) conducted a qualitative analysis of challenges associated with chronic obstructive pulmonary disease (COPD). They identified an overarching theme of "living with the disease and one's spouse in a new and changeable life rhythm," with three underlying themes of "living with uncertainty," "living in a changed intimate relationship," and "finding new ways of living together." These themes, particularly uncertainty, are challenging stressors to couples and families living with COPD as the illness progresses into the terminal phase.

Couples' Adaptations to Illness

Many types of adaptations may be necessary when a partner becomes ill. Ideally, couples demonstrate flexibility and allow established roles to shift. While these shifts first may occur at the "daily chores" level, broader role changes, including shifts in emotional/relational roles, may be necessary. The "tasks" associated with this adaptation reflect how the demands of the illness interact with the couple's tasks related to their family and couple life cycle stage. For example, role strain takes on a different form when a woman becomes seriously ill during the early years of childrearing, particularly if she has been the emotional center of the family. If she is the primary caregiver, her partner may need to become more engaged in household management and more attuned and responsive to the children's emotional needs. If the ill partner is the primary breadwinner, the family may experience financial difficulties unless the well partner is able to increase work life and make greater financial contributions. If the ill partner typically managed the couple's emotional life, the partners may need to covertly or overtly renegotiate this role to maintain relational emotional health. Gender-related socialization may play a major role in a couple's ability to adapt (McDaniel & Cole-Kelly, 2003). Couples struggling with adaptation may benefit from referral for counseling or psychotherapy.

Shifting role issues may be particularly difficult to manage when other family members avoid communicating about important issues with the ill person out of fear of stressing them, believing that can exacerbate the illness. The desire to protect can be a strong deterrent to open conversation. If the ill person typically initiated difficult conversations, their depleted physical or emotional energy may reduce their ability to corral their partner or the family for dialogue, thus impeding the recognition and resolution of relationship issues.

Couples facing major health care issues may also need to make major lifestyle changes. Dietary changes, smoking cessation, activity level changes, schedule changes for administration of medicines, and/or other changes in daily routine affect and are affected by family members. Family members can help or hinder the ill person's attempts to make lifestyle changes. Sometimes family members may themselves need to make changes (e.g., one partner stops smoking to help the ill partner manage breathing problems). The couple's ability to adapt to these changes as a unit, and to discuss the issues these changes create, is one factor in determining overall coping (McDaniel et al., 2014).

Family and couple behavioral patterns also may affect the person's ability to "self-manage" their chronic condition. For example, critical, overprotective, controlling, and distracting behaviors from family members are associated with less effective self-management and negative patient outcomes (Rosland, Heisler, & Piette, 2012).

Communication can be a challenge. The couple needs to find a supportive way to communicate about all the stresses the illness places on both partners. This sense of "communion" (McDaniel et al., 2014) both mitigates the conflict that is bound to arise at a stressful time and gives both partners a sense that they are there for each other. Couples often need to reach out to other people who have experienced similar challenges to help them normalize their experiences and seek coping strategies. However, there is no "one size fits all" prescription for couple communication in the face of illness. Badr (2017) notes that couples facing cancer may not benefit from a "generic prescription to talk openly about cancer." Rather, she suggests helping couples reflect on their strengths, build on existing communication patterns, and engage supports to improve patient and partner quality of life.

The couple benefits from educating themselves about the illness and its various elements, including what aspects of the experience they can and cannot control. The reality that some aspects of the illness are immutable can lead to a debilitating sense of overall helplessness. Couples typically cope better when they generate a sense of "agency" in dealing with the illness by differentiating between uncontrollable and controllable issues, focusing on those that are controllable (McDaniel et al., 2014).

Couples typically search for meaning in the illness. Both the individual with the illness and the partner commonly ask, "Why me?" Like any challenge, illness is an opportunity for reflection and change. This process often helps the couple make meaning of the experience. It may give the couple a sense of peace and acceptance (Palacio, Krikorian, Gómez-Romero, & Limonero, 2020).

Couples also grieve for losses associated with the illness. Loss issues are most overt during terminal illness, when the couple copes with the anticipated loss of life. Partners often avoid discussing death out of a desire to protect themselves and each other from this grim reality. Even a well partner's mortality fears are roused by watching a close loved one die. Typically, partners who are able to discuss the ultimate loss productively are better prepared to make critical decisions at the end of life, such that the surviving partner is better able to cope after the death of the other partner. Porter, Fish, and Steinhauser (2018) identified key themes in couple's communication toward the end of life in cancer patients: affirmation of the whole person, pain and symptom management, contribution to others, completion, clear decision making, and preparation for death.

Even non-life-threatening illnesses are accompanied by many other, less obvious losses (Falvo & Holland, 2017). The partners need to grieve for the loss of their preillness life. Increasing dependence may limit the activities of the partner as well. Partners may lose the ability to be sexually intimate. They need to grieve actively for the changes in functioning they experience and find new ways to meet the needs affected by these changes in functioning.

Still another source of stress that affects overall coping can be the couple's interactions with the health care community. Negative, preconceived ideas about and experiences with medical care professionals may complicate the relationship with the health care team. Establishing a trusting, positive relationship can be particularly challenging for couples from marginalized and minoritized communities given that they often receive suboptimal care and have poorer health outcomes (National Center for Health Statistics, 2016). Minoritized communities are well aware of the history of the medical community taking advantage of the poor and people of color in medical research. The high level of medical mistrust, based in systemic racism within the medical system, has been cited as one important factor in health disparities (Jaiswal, & Halkitis, 2019). Issues with quality or care and fragmentation of care can frustrate and reduce the couple's sense of connection and trust in the health care team (White & Newman, 2016). The couple and the health care team must learn to work together with a shared mission to return the ill partner's health or maximize their quality of life.

Problematic Patterns

The stress of illness can set the stage for the development of maladaptive patterns related to care burden. To some degree, the need for adaptivity depends on the patient's caregiving needs and functional status. For example, 52% of partners of patients with chronic pain, who typically have high levels of functional impairment, rated the caregiving burden as "high to severe" (Suso-Ribera, Yakobov, Carriere, & García-Palacios, 2020). Usuba, Li, and Nowrouzi-Kia (2019) compared disease burden across many chronic conditions, concluding that the impact on health-related quality of life was most challenging in pain and mood disorders, but most disruptive for stroke. Notably, all of these conditions cause considerable impact on daily functioning.

Caregivers often struggle to obtain support, either because they do not ask or because other family members are unable or unwilling to help. Whereas earlier research indicated a high level of depression in caregiving partners (Tsai & Jirovec, 2005), more recent research indicates that the relationship may be complex. A systematic review of the literature on caregiving at the end of life concluded that finding meaning in the caregiver experience, social support, and caregiver resilience throughout the caregiving experience mitigate negative caregiver impacts (Palacio, Krikorian, Gómez-Romero, & Limonero, 2020). Caregiver support has become more central to care, with increased research attention to caregiver interventions (Harding, List, Epiphaniou, & Jones, 2012). Overall, it does appear that caregiver support programs improve caregivers' well-being, with a focus on social support and self-care as emerging key elements (Fu, Zhao, Tong, & Chi, 2017).

The stress of illness can also exacerbate premorbid maladaptive patterns. Communication difficulties, old resentments, patterns of over- or underfunctioning can become entrenched or intensified when adaptability and support are needed most. A systematic review of couples interventions (Martire, Schulz, Helgeson, Small, & Saghafi, 2010) found that targeting the couple's focus on patient health behavior facilitated improvement. In couples with high levels of illness-related conflict, targeting low support and relationship quality were most impactful.

Other research themes have focused on dyadic coping in couples with chronic disease. "Dyadic coping" refers to the interplay of the dyad's communication when stressed, the partner's response to these stress signals, and the dyad's relative success in joint problem solving. Couples with strong dyadic coping share the burden of illness as "our" problem and support each other in the context of the stressor in a way that is "in sync" with each other. Couples facing cancer who evidence strong dyadic coping maintain their relationship in the face of this stress. Those couples who attempted to protect the other with reduced communication, or were unable to retain a supportive stance toward one another, experienced a deterioration in the relationship (Traa, De Vries, Bodenmann, & Den Oudsten, 2015).

Along these lines, Rolland (2018) encourages therapists to assess for "relationship skews" that occur when one person is debilitated by illness and the other must adapt. A resulting power differential can lead to resentment and tension within the couple, and a sense that the illness "belongs" to one person rather than being a burden to be shared by both. Couples often need assistance recognizing the pattern, accepting the associated emotions, and finding methods to rebalance their relationship (McDaniel et al., 2014).

Another challenge the couple must navigate is the social isolation that is common during serious illness. The reduction in activities, the need for caregiving, and other factors often preclude socializing. In addition, friends and family members may withdraw because they do not know how to be supportive or are overwhelmed by their own emotional reactions to the illness. This emotional distancing occurs just when both individuals within the couple most need support.

Even within a couple, the illness can increase emotional distance. Some partners find that an illness is like having "an elephant in the living room" that cannot be discussed. It is not uncommon for each member of the couple to avoid talking because that person believes that the other "can't handle" talking about the illness. Protecting oneself in the guise of protecting a loved one is a common dynamic, reflecting a lower level of dyadic coping.

Each individual within a couple must find their own way to cope with the illness. Sometimes different levels of acceptance and coping mechanisms clash, resulting in conflict. For example, if one member withdraws in an attempt to shield self and others from pain, the other may feel abandoned by the distance. Denial is another coping strategy that each member of the couple may use differently. Denial can be healthy, helping one to tolerate massive stressors. However, too much denial can be problematic, particularly when it interferes with appropriate treatment or lifestyle alterations. A couple with differing levels of denial may experience conflict if one person feels that the other is making too much of a small issue, while the other feels that critical issues are being ignored. Denial may be more common and detrimental when the partners face an illness with an unclear prognosis or treatment plan.

Case Illustration

Karl was diagnosed with a rare bone cancer at the age of 39. His family physician, Dr. Jackson, had difficulty telling him his cancer was likely to be fatal. Rather, she waited for the oncologist and the surgeon to tell him the prognosis. However, no one made this clear. Karl came to Dr. Jackson and seemed to indicate in a roundabout way that he wanted to know what his tests showed. Dr. Jackson thought about Karl, his wife Debra, and their 2-year-old twins. She told Karl that it was important for them to talk about his illness, and to schedule an appointment when his wife could come along. In the meantime, Dr. Jackson told her psychologist collaborator (SHM) about the meeting and asked that she join them. Dr. Jackson was concerned that Karl was not ready to hear his terminal diagnosis. She said that she knew little about Karl's family, his wife, or her understanding of Karl's illness. The psychologist encouraged her to start with a brief genogram to assess family support and the family's previous experience with illness. Then they could elicit what they knew about the illness.

Within a few days, Karl, Debra, and the two professionals met. The genogram was quite helpful in assessing the couple's support network. When Dr. Jackson asked what they knew about the illness, Karl responded that he knew he was dying, although no one had told him this directly. He said that his wife refused to accept this. When Debra anxiously turned to Dr. Jackson for reassurance, Dr. Jackson told her the difficult news: "Karl is right. He has a cancer that's not curable." Debra began crying and said angrily, "Well, how much time does he have? Six years? Six months?" Dr. Jackson responded, "We don't know for sure, but it's likely to be closer to 6 months." Debra began wailing, then turned to her husband: "But my plan was to grow old with you. You can't leave me now." The session lasted 45 minutes, with the psychologist encouraging the couple to ask questions, talk to each other, begin planning how best to use the time they had left, and think about how to communicate with the twins. In fact, Karl was already making a video, talking to the twins about his own life and his wishes for theirs. The session ended without a dry eye in the room.

Sometimes differing levels of acceptance and understanding of the illness may underlie what appears to be denial in the couple (McDaniel et al., 2014). Even nonterminal illnesses require an acceptance process, with each member of the couple and family progressing through this process at different speeds. Robinson (2017) studied families that perceived themselves as 'living well" with chronic disease. Her qualitative analysis revealed a recursive process with five phases: the fight, accepting, living with the chronic illness, sharing the experience, and reconstructing life. The first three phases focus on the family's relationship with the illness itself, as they slowly respond and adapt to the illness demands. The fourth phase reflects the family's internal process to reconfigure around the illness and integrate it into daily life. The fifth stage describes the family establishing a new normal in which the illness is no longer "front and center" in daily life. Each individual's navigation of this process can set the stage for a sense of synchrony or conflict.

The acceptance process can be facilitated or hampered by characteristics of the illness. For example, an illness that remits and returns may force the couple to go through an acceptance process many times over. An illness that does not coincide with the course and prognosis predicted by health care professionals also may confound the couple. Differing levels of acceptance can create conflict, particularly regarding treatment or end-of-life decisions. Greater conflict has been found to correlate with disagreement regarding the perceived wishes of the patient (Parks et al., 2011).

Couples also must make adaptations when parents are faced with the disability or serious illness of a child. Clearly, raising a child with a developmental disability or a chronic illness can be a challenge. Despite these challenges, research regarding marital satisfaction in couples with disabled children has been mixed, with results ranging from a negative effect on marital satisfaction to no effect or a positive effect (Goepfert, Mule, von Hahn, Visco, & Siegel, 2015). Similar disparate results have been obtained in studies of couples facing the chronic illness of a child (da Silva, Jacob, & Nasciemento, 2010). Paternal involvement in managing a serious medical condition may mitigate some of these challenges (Swallow, Macfadyen, Santacroce, & Lambert, 2012). Given the complexity of these situations, it is important that couple therapists be alert to the health status of children and evaluate its effect on stress levels and marital functioning.

THE PRACTICE OF COUPLE THERAPY FOR MEDICAL ISSUES

Structure of the Therapy Process

A couple therapist may need to suggest inviting the ill person's partner into therapy because patients with illness often present alone. Including the partner helps them co-create a shared experience and approach toward the illness experience, which has been associated with lower levels of illness related distress (Berg & Upchurch, 2007). Couple-based interventions in the context of chronic disease are associated with small, but meaningful, benefits over individual approaches (Martire et al., 2010). It is also often helpful to expand the treatment to include other significant, extended family members who affect, or are affected by, the illness. Session attendance plans should be fluid, since the patient and partner may identify more relevant people as treatment progresses. Individual sessions may help the therapist respond to particular stressors or to explore an issue more thoroughly. People outside the biological family may facilitate assessment and increase the couple's sense of social support. Finally, members of the health care team obviously affect the illness and (perhaps less obviously) may be affected by the illness as well. Including members of the health care team, even when the interface between the couple and the team is not problematic, can be very helpful. Joint appointments attended by members of the health care team give the couple and other family members opportunities to ask questions about the illness. This may alleviate fears that someone is hiding critical information. Joint appointments are much easier when the couple's therapist and medical team are co-located but can be accomplished even when this is not the case using telehealth or by holding the meeting in the medical office (Ruddy et al., 2008).

Case Illustration

Dr. Giancomo, Alice's neurologist, attended the last 15 minutes of the first session with Alice and her husband. In response to the psychologist's request, he described Alice's hospitalization, the tests she took, and the certainty of the health care team that she did not have epilepsy. Instead, he said, she was experiencing stress-induced, nonelectrical seizures. He praised the couple for having the courage to come to psychotherapy and said he was certain that Alice and her husband, Bob, would benefit from their work with the psychologist.

Collaboration with health care professionals gives therapists who are unable to prescribe psychotropic medication built-in consultants regarding these issues. Psychotropic medication can be particularly helpful when depression or anxiety significantly impairs a patient's functioning and optimal ability to self-manage the illness. Giving patients information about psychotropic medication and helping them decide whether and when they feel it could be helpful, constitute another opportunity for agency. Furthermore, there is strong evidence that patients with both chronic medical conditions and depression have worse outcomes than those without a mental health disorder so it is imperative that mood issues be treated optimally (Katon et al., 2010). These issues are also discussed in Chapter 26 on depression and anxiety, in this volume, by Whismen, Beach, and Davila.

For those patients whose health condition or geographic location complicate or preclude in-person psychotherapy, Internet-delivered cognitive-behavioral therapy for depression and anxiety appear to reduce symptomology (Mehta, Peynenburg, & Hadjistavropoulos, 2019). Cognitive-behavioral therapy for couples and families facing illness have been found to be useful (Fischer, Baucom, & Cohen, 2016). With the COVID-19 pandemic, all kinds of psychotherapy, including couple therapy, is being delivered by telehealth. Chapter 30 by Doss, Knopp, Wrape, and Morland, in this volume, reviews best practices in telehealth and digital couples interventions. Studies of impact are ongoing, but initial response indicates that telehealth has many advantages. For example, connecting with the therapist from home reduces stress for couples for whom an office visit is challenging due to health issues.

Whenever possible, health care professionals should be included in therapy when problematic patterns develop between the couple and the treatment team. Resolving or improving problematic interactions with the treatment team also can create a sense of agency. Health care professionals also benefit from learning about the couple's coping, and how the team can improve the care of this patient, couple, and family.

Some therapists who work primarily with couples facing illness choose to work embedded as part of team-based care in a health care setting. This context changes the structure of therapy in a number of ways. The therapy room may be an exam room, making it easier for physicians to participate in a session, or for the therapist to join the physician in an exam room for a warm hand-off. Many therapists who work in medical settings have noted that patients and their partners who seek psychotherapy in a medical setting may be at a lower level of readiness to change. Evidence suggests that attending to "readiness for change" and adapting care plans accordingly may enhance the impact of treatment, particularly in helping patients make health behavior changes (Prochaska et al., 2005).

Therapists who provide services in team-based care environments find that some people attend psychotherapy because of the treatment team's expectations or recommendations rather than an insight regarding the need to resolve emotional or relational issues. The medical professional, rather than the patient, may be the "customer" for the psychotherapy. Under these circumstances, the therapist needs to recognize the potential for motivational issues and assess the couple's willingness to attend therapy. If the couple agrees to continue, the therapist may need to adjust expectations and pacing, and begin with basic psychoeducation about how therapy can help the couple cope. If the partners are not interested in psychotherapy, the therapist can consult with the health care professional regarding the concerns that drove the referral. The therapist and health care professional can discuss how to manage the concerns in the interim, working to increase motivation over time for referral to specialty care. Therapists who plan to work in team-based care environments must become expert at the skills inherent in consultation and may need to seek additional training and experience to fulfill this role optimally. (These skills are discussed in more detail below in "The Role of the Therapist.")

Another result of practicing in close alignment with medical professionals is a different pace of therapy than is often seen in other settings. Because patients usually go to their health care clinicians on an "as-needed" basis, they may seek psychotherapy only when they feel it is immediately necessary. This pattern can disrupt the traditional "joining/assessment–midphase–termination" cycle of psychotherapy. However, the flexibility of this therapeutic process reflects the reality that couples living with illness have different needs at different times and may therefore need different "doses" of therapy over time. It is common for patients to be seen less frequently, and for a shorter duration. Yet research indicates that even one or two consultations can lead to lasting and meaningful improvement in well-being, symptom reduction, and functional status (Bryan, Morrow, & Appolonio, 2009). In addition, ensuring that therapists focus on those couples most likely to benefit from sessions at a given time facilitates population-based care, meeting the needs of more people than traditional ongoing therapy.

Case Illustration

Dr. Hanover, a family therapist, worked as a behavioral health consultant in a busy primary care clinic. One of the physicians, Dr. Moore, acknowledged struggling with a patient during the team's morning huddle. Dr. Hanover spoke with Dr. Moore later in the day to offer her assistance. Dr. Moore shared that her patient, Brianna, has asthma and had been hospitalized three times in the last 6 months because of exacerbations. Dr. Moore was frustrated because Brianna's husband, Michael, "refused" to stop smoking in their home, and she attributed Brianna's asthma exacerbations to the household smoke. Dr. Hanover asked more and learned that Dr. Moore had never met with Michael. Dr. Hanover suggested that Michael be invited to a future appointment to discuss his perceptions of Brianna's troubles with asthma. Furthermore, she coached Dr. Hanover *not* to discuss smoking cessation with Michael given their nascent relationship. Dr. Moore followed Dr. Hanover's advice, obtaining Brianna's permission to invite Michael to their next appointment, and reaching out to Michael directly. Although she felt compelled to confront Michael about his smoking, she was able to focus on joining with Michael during the phone call. Prior to the appointment with Brianna and Michael, Dr. Hanover asked Dr. Moore to help her think through the agenda for the visit. They agreed it should focus on eliciting Michael's concerns and thoughts on the best path forward. Dr. Hanover reminded Dr. Moore about the motivational interviewing strategy of "asking permission" before discussing sensitive topics or offering resources. During the appointment, Dr. Moore learned that Michael was extremely worried about his wife and was very invested in helping her. When Dr. Moore asked Michael about his attributions for Brianna's struggles, he became upset. He acknowledged that his smoking was part of the problem, and said he had "cut down" on smoking in the house. Brianna defended Michael, saying "He does the best he can." Dr. Moore could sense this was a very sensitive conversation and remembered Dr. Hanover's advice to ask permission before charging forward. Dr. Moore first normalized the difficulties of smoking cessation and reinforced Michael's efforts to cut down. She reflected on how much he clearly cared about Brianna, and his desire for her to avoid future hospitalizations. She then asked if they would like to hear more about ways to help Michael reduce or even quit smoking. Brianna again defended Michael, denying that his smoking and her hospitalizations were linked. Dr. Moore waited to let Michael respond. After some time, Michael said he did want help because he knew that smoking was harmful to both Brianna and himself. Brianna seemed very surprised but agreed that it might be helpful. Only after both Brianna and Michael stated that they wanted to learn more did Dr. Moore share the practice's smoking cessation resource. Dr. Moore tried get Michael to set a "quit date," but he declined. He did agree to come to another appointment.

Later that day, Dr. Moore caught Dr. Hanover in the hall and shared Michael's progress toward smoking cessation. She expressed some frustration that the appointment had not resulted in more progress, but Dr. Hanover reflected that change takes time. The next month, Brianna had another hospitalization. When Dr. Moore checked on Brianna in the hospital, Michael was in the room. He asked Dr. Moore to step outside with him. He started to cry and expressed his anger at himself for "being selfish and smoking." Dr. Moore empathized again and reminded Michael of the smoking cessation options at the practice. Later that day, Michael called the office and registered for the next smoking cessation group. After two rounds of group education and nicotine replacement therapy, Michael was eventually able to quit.

The Role of the Therapist

One means of empowering a couple is to take a collaborative stance toward the therapy. Although a therapist may have expertise in helping couples cope with illness in general, each member of the couple is the expert on their own illness experience. The therapist can normalize reactions that patients sometimes find confusing or painful (e.g., anger), facilitate communication and dialogue, and help the couple find both agency and communion. A collaborative stance minimizes any experience of psychotherapy as disempowering or imposed upon the couple, the way they may experience other aspects of the overall treatment plan.

This collaborative stance is effective in the consultative relationship with other health care clinicians as well (Hunter, Goodie, Oordt, & Dobmeyer, 2016). Consultation with a fellow professional should begin with a thorough understanding of the other professional's understanding of the situation, and of their specific concerns and goals. It can be tempting to rush into recommendations, but leading with empathy, acknowledgment, and affirmation of the clinician's good work facilitates successful consultation. Only after this professional connection has been established should the therapist make recommendations for assessment questions and interventions. A collaborative, consultative relationship facilitates a parallel collaborative relationship between the patient and health care professionals as well.

Especially because of the need to confront very difficult physical and emotional experiences, therapists should engage in a self-reflective process vis-à-vis their own experiences, biases, and beliefs about health and health care. Personal experience with illness must be acknowledged and carefully managed to focus on the couple's unique illness experience. The therapist's own family-of-origin experiences concerning health and illness may inform the therapy, just as other family-of-origin experiences can be helpful or hindering in other psychotherapy (McDaniel et al., 2014). Typically, therapist self-disclosure may be tempting but can distract patients from their own issues.

Case Illustration

Theresa was referred for psychotherapy because she was having difficulty coping with multiple family problems. It quickly became apparent that she had coped with stress somatically for much of her life. Her husband, Larry, agreed to attend psychotherapy with her, primarily out of frustration about how her many illnesses affected the family. One major issue acknowledged by both Theresa and Larry was a rift between Theresa and their adult daughters. Larry frequently felt caught between "the girls" and his wife. Both were angry that their daughters were not more understanding of their mother's physical problems. In a useful self-disclosure, the therapist (NBR), who was about the same age as their daughters, discussed her own experience with her mother's cardiac illness (which had resulted in a heart transplant). She noted that even though she understood that her mother was not to blame for her illness, there were times when it was difficult not to feel at least "cheated" because her mother was not healthy. This seemed to help Theresa and Larry look at the situation as their daughters might have experienced it. They began to recognize how this sense of loss for the daughters might be particularly strong given that their mother had often been unable to mother them when they were younger as well.

Some therapists are more likely than others to enjoy and thrive in the health care environment. Nash, McKay, Vogel, and Masters (2012) outlined therapist characteristics that tend to work well in integrated, team-based care. Therapists who understand and are drawn to the complex interplay of biological, psychological, relational, and social elements of the illness experience may be drawn to helping couples cope with illness. Therapists who enjoy working as part of a team and are willing to collaborate with other health care professionals may thrive in a more medicalized environment. Clearly, therapists with very negative feelings about the medical profession or health care system are less likely to enjoy collaboration with a medical team, less able to tolerate issues that press "antimedicine" buttons, and more likely to be triangulated when a couple experiences difficulties with the medical system. Regular peer consultation is important for all therapists who work with couples and medical issues.

Assessment and Treatment Planning

Overall, therapists should be aware that illness might be a part of the context for any couple's presenting concern. Either patients or therapists can fail to make the connection between illness and the need for treatment. Every couple that presents for couple therapy should be asked whether either partner (or close family member) is now ill or has previously had a significant illness. When patients present alone, the therapist can broaden the focus to the couple and family by asking questions that bring others' perspectives and experiences into the dialogue, even if they are not physically present. We list questions that can facilitate this in Table 28.1.

TABLE 28.1. Questions to Elicit Patient's and Family Members' Illness Perceptions

For the patient

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a long or short course?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?
9. Should we expect complications?
10. What has been your extended family's experience with illness?
11. Has anyone else in your family faced an illness similar to the one you have now? If so, what was its course?
12. What is your and your family's past history of recuperation?
13. What might make healing now a struggle for you?
14. Do you see yourself as having much to live for?

For family members

15. What changes in family responsibilities do you think will be needed because of the patient's sickness?
16. If the patient needs care or special help, what family members are going to be responsible for providing it?
17. If the illness is already chronic or appears likely to become chronic, what are the patient's and family members' plans for taking care of the problem over the long term?

Note. The first eight questions are taken from Kleinman, Eisenberg, and Good (1978). Questions 9 and 10 are adapted from Seaburn, Lorenz, and Kaplan (1993). Questions 11 through 14 are adapted from Friedman (1991). Questions 15 through 17 are from Shields, Wynne, and Sirkin (1992).

Including assessment of family and relational levels aligns with the biopsychosocial model (see also Chapter 2 on assessment, in this volume, by Snyder & Balderrama-Durbin). But therapists must reach beyond these relative comfort zones to assess the impact of both biological processes and social and community issues. Working with other professionals can be critical to help couple therapists better understand the biological and social context of an illness. Collaboration facilitates gathering information about the illness, its treatment, and its prognosis, and understanding the patient's relationships with the health care system.

Helping the couple create a "time line" of the illness facilitates assessment. The therapist should ask about the onset of the illness; illness symptoms; diagnostic process and diagnosis; treatments that have been suggested, tried, or desired; the couple's emotional and practical responses to the illness; and the patient's current condition.

Gathering genogram information allows the therapist to solicit an illness story that may have unfolded over generations, shedding light on the couple's general scripts about illness. This is particularly important if the illness is common to many family members or has a genetic component. Under these circumstances, the couple may have strongly set expectations, fears, or beliefs about various treatments based on family "lore." The time line should include previous and ongoing interactions with the health care system and how they might relate to the couple's current experiences and stance toward their medical team and the medical system as a whole.

Beyond specific illnesses in the family, it is helpful to hear how the couple and family traditionally have dealt with illness and its history with the health care system. Again, these can be sources of expectations, fears, and myths that help the therapist understand the couple's adaptation to the illness. Stretching the time line to include the couple's expectations of the future is also useful. If the illness is terminal, it is helpful to assess the couple's (and each individual's) acceptance level. Since most illnesses cause numerous permanent and temporary losses, the therapist should assess the couple's levels of acknowledgment and anxiety about these losses, as well as their ability to tolerate overt conversation about them.

Case Illustration

Maria was referred for psychotherapy with one of us (NBR) to help her cope with her declining health related to COPD. Her physician was frustrated because Maria continued to smoke even as her lung function deteriorated. Her husband and other family members were frustrated with her because they felt Maria was not being honest with them about her illness and did not trust that she was caring for herself. In a family meeting (which included her husband and three of her four children; the therapist; and her primary care physician, Dr. Grange), the children discussed their experience of Maria surviving ovarian cancer a decade earlier. Maria and her husband had colluded to hide her cancer from the children and had never told them that she might die. As they faced a new illness experience with their mother, they did not trust their parents to be honest with them. Couple therapy helped Maria and her husband begin to share more openly with their adult children. They were able to understand that despite their intention to protect the children, their decision to hide the truth had been very hurtful. In concert, family sessions focused on contextualizing their earlier lack of transparency as a desire to protect the children out of love. Helping the children understand the parents' behavior through this lens helped to engender trust. The family processed the likelihood that Maria's illness would ultimately be terminal, although they recognized that her downward course would take years.

It is helpful to assess the impact of the illness experience on the patient's and couple's functioning. This functional assessment elicits how life has changed in the context of the illness, with a specific focus on its impact on work, relationships, and leisure/pleasure activities. In addition to helping the couple identify specific impacts, this discussion can elicit areas that the couple finds particularly troubling. These "pain points" often reveal what matters most to the couple and can facilitate collaborative goal setting and treatment planning (Mueller et al., 2020).

A therapist also should investigate a couple's preillness level of functioning. Understanding the partners' lives before the illness provides a context for the current situation. This discussion highlights adaptations and helps the partners recognize how they have controlled what feels uncontrollable. When the illness has caused functional impairment, this discussion also can shed light on the patient's personality and functioning prior to the illness. The therapist also should elicit and acknowledge strengths the partners bring to their struggle. Often these strengths form the basis of maximizing the couple's quality of life and adaptation.

Beliefs about the causes, meaning, and treatments for health conditions are firmly rooted not only in one's individual family but also the larger cultural fabric. At the same time, therapists must take care not to stereotype or make assumptions about cultural factors in health, approaching these conversations with respectful curiosity.

Intrinsic to this discussion is the assumption that the couple benefits from the assessment; it can help them better understand themselves and put their current situation in a coherent context.

The processes of telling one's illness narrative, and hearing how other family members have experienced the illness, are powerful and therapeutic in and of themselves.

Goal Setting

The primary goal for couples facing illness is to adapt to the changes that illness has thrust upon them. Couples may need assistance in forming smaller goals that enhance their overall adaptation and functioning. Common goals include improving preexisting issues that block adaptation and teamwork, finding meaning in the illness, taking control over the controllable aspects of the illness, accepting the uncontrollable aspects for what they are, and learning to live around the illness. Couples need to improve communication in general, and about the illness specifically. In addition, many couples need assistance in communicating with the health care system.

Two general goals that underlie successful adaptation and must be balanced are "agency" and "communion" (McDaniel et al., 2014). Couples can feel overwhelmed and powerless in the face of illness, resulting in increased passivity that is reinforced by the health care system and the "patient" or "illness" role. Patients who have "agency," active involvement in their own care and acceptance of what they cannot change, tend to adapt more successfully.

Patients need a community around them to provide support. Psychotherapy facilitates communion by helping couples join together and draw in other family members who distanced themselves either prior to or in response to the illness. Finally, the therapist can help a couple and family connect with others facing similar challenges, for example, through in person and online support groups, social media, and advocacy groups (Petrie & Jones, 2019).

Case Illustration

Alice, mentioned earlier, had a history of seizures and depression. After hospitalization for seizure evaluation, Alice's neurologist said that she had nonelectrical seizures that he felt were rooted in marital problems. He sent Alice and her husband to a couple and family psychologist (SHM). In the first session, Alice stated that her goal was "to have my husband stop blaming me and to stop being so dependent" on her for household chores. Alice agreed when the psychologist suggested goals to stop accepting blame for problems, and to stop babying her husband. Alice's husband, Bob, stated that his goal was to help his wife "in whatever time she had left on this earth." After Alice noted that she felt Bob needed antidepressant medication, Bob acknowledged serious mood swings, but said, "They have no effect on our marriage." With Bob's agreement, the psychologist suggested that Bob's goals were to help his wife physically and emotionally, and to evaluate the effect of his mood swings on the couple and family. As is true in many couples, Alice experienced too much communion and not enough agency, whereas Bob had too much agency and not enough communion. Therapy thus focused on achieving balanced agency and communion.

Rolland (2018) has focused specifically on the effect of illness on intimacy. He notes that illness challenges both physically and emotionally the "intimacy homeostasis" a couple has evolved over time. The first challenge to this homeostasis is the real and anticipated losses associated with illness. Loss is not always associated with negative emotions, and a direct focus on the loss may not be the most helpful course. Rather, Rolland suggests that the therapist help the couple see the threatened loss as an opportunity to live more fully in the present, and to broaden the partners' experience of intimacy.

The second challenge to intimacy involves changes the partners must make in how they communicate. Partners must find a "functional balance" in their communication. In other words, they must discern which fears, feelings, and thoughts need to be shared (no matter how difficult this may be), and which are best kept to themselves. Illness issues and adaptations are difficult to discuss because so many of the associated fears, feelings, and thoughts are overwhelming or shameful, and the partners want to protect themselves and each other. The anger that accompanies illness can be particularly challenging for couples. A therapist can help the couple by normalizing these intense experiences, and by helping the partners to share their experiences rather than allowing them to create distance.

Rolland (2018) also stresses rebalancing relationship skews that occur in relation to the illness. If the illness is seen as only one person's problem, the relationship will be redefined around inequality in the couple, which can result in lower levels of dyadic coping, including decreased intimacy, resentment, guilt, and emotional distance. Redefining the illness as "our" problem acknowledges the illness-related changes that both partners experience, allowing the couple to discuss and challenge their preconceptions about “appropriate” roles of the ill and the well partner. A couple may need assistance in breaking out of prescribed roles about illness based on family-of-origin experiences with illness and gender.

Emotionally focused couple therapy (EFCT) with couples facing illness emphasizes helping couples “normalize and validate each partner’s experience, to help partners process their emotional experiences, to externalize negative interaction cycles, and to help partners seek safety, security, and comfort from each other (i.e., create a more secure attachment bond)” (Kowal & Johnson, 2003, p. 304; see also Chapter 6 on EFCT, in this volume, by Johnson, Wiebe, & Allan). This model targets underlying attachment needs, and how these needs relate to health and wellness. The therapist seeks to “deescalate” rigid, problematic cycles of interaction by helping each member of the couple identify and manage their emotional experience of established patterns. As patterns and the related emotional responses are acknowledged, the therapist then seeks to balance the couple’s tendencies toward withdrawing from and/or blaming the partner for these patterns, to address the common “pursuit–withdrawal” interactional pattern. This intervention also enables the couple to address their desire for balance and security in the relationship. Finally, the therapist works to help the couple consolidate and integrate these therapeutic gains into their daily lives, particularly in the context of areas of disagreement or stress (see Johnson et al., Chapter 6). The EFCT process is well suited to helping couples cope with the losses inherent in chronic and serious illness that can exacerbate any existing couple dynamics around attachment.

Case Illustration

Karen and Joel had a very unstable marital relationship. Both attributed many of their difficulties to Karen’s long-standing bipolar disorder. After much struggling, Karen started to improve after taking a mood stabilizer. However, the couple’s dynamics around her mood disorder continued to be a problem. Joel harbored resentment about old incidents, particularly some financial difficulties related to Karen’s mood swings. He blamed Karen and expressed that there was nothing he could do to improve their relationship. He refused to take any responsibility, including financial problems related to his own behavior. He clearly felt powerless to help Karen and was torn between his love for her and his anger. Even when Karen’s condition stabilized, he had difficulty shifting out of this powerlessness. Ultimately, the couple separated and divorced. Only with distance and individual therapy did Karen recognize how her illness was a large factor in her “lightning rod” position in many relationships. She acknowledged the relationship dynamic in which she was “the sick one” and Joel was the “victim” of her illness.

Illness can be like a new, unwanted family member. Like any other family member, the illness itself can be the third point in triangulation of conflicts, reducing the couple’s ability to resolve issues as a dyad. Also, when the illness is the source of resolution of some problem (albeit an unhealthy resolution), the illness becomes necessary. This can interfere with restoring health and increase the likelihood that relational issues or secondary gains support symptoms. When the illness becomes a central point in the couple’s dynamics, the therapist must help the couple realign the relationship to make this third point of the triangle less necessary. The demise of Karen and Joel’s relationship after Karen improved illustrates what can happen when the illness is central in how the partners relate to each other.

Process and Technical Aspects of Couple Therapy

McDaniel and colleagues (2014) outline a number of key principles and techniques in family and couple therapy. The first is to recognize the biological dimension of a couple’s or family’s problems. In some forms of family therapy, the family’s labeling of one member as “sick” is seen as part of the problem. In couple therapy focused on medical issues, the therapist accepts the couple’s definition of the problem as a medical illness. Including physicians in one of the initial encounters to explain the illness, its prognosis, and its probable course ensures that therapist, patient, and family members all have the same information about the illness. This dialogue can demystify the illness for the couple and give them the opportunity to ask questions.

Relational and intrapsychic issues exacerbate even the most biomedical of illnesses. When the health care team has been unable to find a biomedical explanation for symptoms, the therapist and treatment team must avoid assuming a psychosocial or “stress-related” etiology. Illnesses that defy diagnosis and a clear treatment plan can be particularly challenging for a couple. They may feel blamed for the illness, confused because they do not understand the source of the problem, or frustrated because they are not sure how to proceed. These complex, vague, and unclear diagnostic presentations benefit from a team-based approach (McDaniel et al., 2014; Van Houtven, Hastings, & Colón-Emeric, 2019).

Case Illustration

Theresa and Larry, described earlier in the chapter, struggled to understand why Theresa so often experienced illnesses for which the medical community did not have ready diagnoses and treatments. Theresa vacillated between being angry with her medical team and feeling guilty. After a great deal of treatment, they became more able to discuss the link between stress and illness in a productive, nonblaming way. Larry tended to believe either that Theresa was "really sick" (e.g., the physicians had a diagnosis, prognosis, and treatment), or that it was "all in her head." Theresa's attempts to "prove" her illness with physicians' testimonials or medical test results caused in overutilization of medical care and diagnostic testing. Slowly Larry and Theresa recognized that both biological and psychological factors were important. This enabled Theresa to begin to discuss and change her lifelong pattern of avoiding conflict and emotional upset by channeling her difficulties into somatic symptoms.

The second technique of medically focused couple therapy is to elicit the illness story. An illness time line helps the therapist understand the couple's journey and helps them recognize the impact of the illness on their lives. Telling the story to an empathic listener is very therapeutic. In one of the first couple sessions Larry and Theresa attended, the therapist completed a genogram. Although Larry was aware that Theresa's father had died of gastrointestinal (GI) cancer, he did not know that six of her father's seven siblings had also died of GI cancer. Theresa recounted how horrifyingly painful her father's death had been, and her fear that she too would develop a GI cancer. She shared that she had been advised to have her GI tract scoped whenever she "felt any kind of twinge" because of her strong family history. Her story helped everyone understand why she was quite focused on body sensations, particularly abdominal issues, and why she sought reassurance that she would not share her father's dreadful fate. The therapist also encouraged her physician to reeducate her about worrisome versus benign GI symptoms, and about modern cancer treatments.

Therapists who focus on medical issues also work to help couples respect defenses, remove blame, and accept unacceptable feelings. A couple facing an illness is in crisis. As in any crisis intervention, the partners' current coping mechanisms are best left intact until they develop new strategies. This is particularly true of the use of denial when it does not negatively affect adherence to prescribed medical regimens. Adaptive denial can give a couple enough hope to face the next day, while not interfering with appropriate treatment or planning for the future.

Couples facing illness can be particularly sensitive and vulnerable to perceived criticism, secondary to a latent sense of guilt about the illness that stems from ideas about fairness and personal responsibility. People want to believe bad things, such as illness, do not happen randomly. This belief system and the links among lifestyle, behavior, and illness often lead to a causal attribution to something they or their health care team did or did not do. Discussing these fears helps the couple accept the illness and relieves blame. Therapists can enhance agency by helping couples develop rituals to heal from events they associate with the illness.

The difficulties people have in sharing negative feelings about their partner can be exacerbated when facing illness. This avoidance can preclude resolution of important issues and increase emotional distance, leaving the ill person even more alone. Medically focused couple therapy can help the couple normalize and accept unacceptable emotions, particularly those that emerge under the stress of illness. For example, the well partner may begin to resent the needs of the ill partner, yet feel guilty about this resentment. Talking about this as inevitable can help the partner recognize the impossibility of saintly behavior, even with someone they love.

Medically focused therapy strives to maintain and facilitate communication in a way that aligns with the couple's readiness to communicate about challenging topics. As noted earlier, a desire to protect one another can create or exacerbate poor communication among family members. It is often helpful to reframe a lack of transparency or secretiveness as a well-intentioned (but unsuccessful) strategy to protect others. Each member of a couple must recognize and acknowledge their own secretive behavior. Often one partner notices the other's secretive behavior but is not aware of their own. Therapists can help partners experience how open communication fosters a sense of support and teamwork.

The couple therapist can also work to improve communication between the couple and the health care system, coaching both members of the couple on how to prepare for medical appointments. The therapist can offer to attend a joint meeting, so that all parties can build a shared understanding of the problem and the approach to treatment. Meetings that include medical professionals help to reduce the triangulation that can occur with the couple and the other professionals. The therapist should maintain open communication with the health care team, modeling collaborative communication and avoiding parallel processes of poor communication among the team, the couple, and the therapist.

The couple may use therapy to process treatment options and make medical decisions. Therapists can help couples identify gaps in their knowledge, to ensure they have truly informed consent regarding different treatment options, including rejection of treatment. The therapist can help the couple and the health care team understand disagreements and nonadherence as an attempt to gain control, and work through "resistance," or disagreement, by emphasizing the temporary nature of all decisions, freeing them to "try out" a suggestion or reconsider hard-line decisions. The goal is to ensure that any and all treatment decisions are in the hands of the couple, and that they have the information and support they need to make decisions that align with their wishes and values. This facilitates a sense of agency and avoids creating a parallel process in which the couple is "nonadherent" with the therapist as well.

Therapist and couple must attend to matters involving both individual and family development, development of the illness and its ramifications, and the interaction between the illness and developmental needs of the individual and family—while not allowing the illness to "take over." Gonzalez, Steinglass, and Reiss (1989) describe this as "putting illness in its place." Couple therapists who focus on medical issues can help couples keep "illness in its place" by encouraging the couple and other family members to maintain routines, rituals, and traditions, and to create space for each family member to get their own needs met as much as possible.

A couple often needs assistance in drawing a boundary around the illness, so the relationship is not entirely defined by the illness. Couples can feel their entire lives and relationship will never be the same again and see themselves as separate from the healthy world. Couple therapists can help compartmentalize the illness. Partners can agree on times when the illness will be the focus of their communication, and other times when it is "off limits." Boundaries can be placed around the occurrence of illness-talk, such as prohibiting it in the bedroom. The couple should maintain social contacts and preillness social routines as much as possible.

Rolland (2018) also notes that the couple needs to adapt illness focus to what is required by the illness at a given time. During a crisis, the illness may be central and all-consuming, but the partners must recognize when a more normal lifestyle can return. Specific information regarding the safety of engaging in more emotionally or physically strenuous activities can help. An overt discussion of resuming their sex life, for example, is particularly helpful because many partners are embarrassed to ask about this and fear that physical intimacy is contraindicated.

Case Illustration

Jerry and Marta came to therapy because they were having difficulty adjusting to life after Jerry's heart attack. Jerry was a heavy smoker, unable to stop until he was hospitalized. Marta came to the hospital every day and, as Jerry said, "watched him like a hawk" thereafter. He had not smoked since. Marta pushed Jerry to eat better, but Jerry complained about the food she prepared and threatened to start smoking again. Before focusing on the needed lifestyle changes, the therapist (SHM) spent two sessions discussing how scary the heart attack had been for them both. In the second session, Jerry broke down and cried for the first time, admitting his fear that he would not live to see his grandchildren. Marta, with support from the therapist, was able to listen and empathize with her husband's fears. Jerry had always been reticent about his feelings, so this was a new experience for both partners. In the fourth session, the therapist asked when they planned to resume their sex life. Jerry was relieved that the therapist brought the subject up and said that both he and Marta were worried about this. The therapist asked Jerry's family doctor to reassure them and answer any questions about sexual activity.

The stress of illness can exacerbate difficulties in a couple's emotional regulation, resulting in an "emotional roller coaster." Watson and McDaniel (2005) outline a seven-step approach to address emotional reactivity in a couple facing illness. They recommend that the therapist help the couple to do the following:

1. Discuss the pragmatic and emotional impact of the illness.
2. Determine how emotional reactivity affects each area of concern, and which areas cause the most anxiety and distress.
3. Refocus on the internal response to the illness and its meaning rather than on how it affects daily living.
4. Discuss emotional reactions, and the internal processes associated with them.
5. Connect the emotions to each person's personal history and vulnerabilities.
6. Facilitate separation of current reaction from reactions to historical triggers.
7. Develop alternative, adaptive responses to current stressors and triggers.

As couples review various issues through this process, they increase their self-differentiation and decrease reactivity, which increases their ability to adapt to the demands of the illness and their sense of agency and communion.

Psychoeducation is also helpful (Smith et al., 2019), preparing couples for possible changes in mood, energy level, behavioral inhibition or disinhibition, and so forth. Psychoeducation can raise awareness of common patterns, helping the couple proactively engage in prevention.

Couples often need assistance in maintaining their connection to their social and support network, fearing that asking for help will alienate or overburden others. Identifying family members and friends who can support them and providing "permission" and encouragement to access these groups, may reduce isolation and caregiving burden. Some couples are more comfortable reaching out to support groups. Finally, the therapist can assist family members in maximizing the benefit from available professional supports in the care team.

In terms of ending treatment, McDaniel and colleagues (2014) advise therapists to "keep the door open"—a principle that medical family and couple therapy shares with most time-limited or brief psychotherapy. Couples often consult with the therapist on an as-needed basis, and the medical team can refer them back for further treatment if needed.

Case Illustration

John and Gerry had been long-term partners when Gerry suffered a serious heart attack. Both men had difficulty with the lifestyle changes encouraged by Gerry's cardiologist and his family physician. Gerry's heart condition required him to change his diet, decrease his stress, and increase his exercise regimen. Because both physicians knew that these changes were much more likely to happen if the partners worked on them together, the couple and the two physicians worked with a therapist (SHM) to develop a plan that was possible for the couple. These goals were accomplished in six sessions over a 3-month period. Because maintenance was of great importance, the couple returned at 3-, 6-, and 12-month intervals during the first year for booster sessions.

MECHANISMS OF CHANGE

Although it is not welcome, illness does create an opportunity for growth. Couples may be able to face intrapsychic and existential issues they otherwise might have avoided. Illnesses can increase partners' awareness of the fragility of life and of simple, daily pleasures previously taken for granted. Illness can make partners appreciate each other in new ways as they contemplate life without each other, and work as a team and support each other. Illness also can force couples to explore new ways of relating to each other as old patterns become less functional. They must broaden their repertoire of interactional patterns to accommodate the illness. Therapy shines light on effective interactional patterns, perceptions, and communications. Therapy empowers the couple to increase agency by taking control over the situation as they can and make informed, intentional decisions. Sometimes partners who learn to take a proactive stance toward the illness take a more proactive stance in other areas of life as well. When the couple begins to view the adaptations as a positive force in their lives, they find meaning in the illness and develop a greater sense of cohesion. The growth catalyzed by illness can result in a more satisfying relationship overall.

Our approach maintains a focus on healthy adaptation and on the strengths couples bring to the challenging transitions imposed by illness. Together, these elements form the essential core of successful couple therapy related to illness. Clearly, this approach integrates many models and applies them to the specific instance of relational difficulties related to illness. The metaframework of the biopsychosocial systems approach with team-based care and collaborative family health care can be layered over many established couple treatments.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

This approach was developed from work with couples facing illness. However, much of it can be applied to couples facing any major life transition. Though all illnesses force transition and adaptation, some are particularly challenging for couples. For example, illnesses that have a genetic component can force a couple to make difficult decisions about childbearing (Hurley, Miller, Rubin, & Weinberg, 2006). Survivor guilt may occur in family members that have been spared the genetic problem. Other health problems directly related to developmental challenges (e.g., infertility) can clearly challenge couples as they attempt to make the transition to parenthood. Infertility assessment lends itself to blame and divisiveness, as the members of a couple seek to determine who has "the problem" that prevents them from bearing children (McDaniel et al., 2014).

Working with couples facing medical illness engenders ethical issues that are less likely to appear in other couple work (McDaniel et al., 2014; see also Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen). Therapists working in a medical setting may encounter different norms regarding confidentiality. Whereas medical professionals typically share the medical record across all health professionals involved in the care, psychotherapists' notes typically are not shared. While, traditionally, therapists' have considered their notes sacrosanct, therapists working in health care often do share notes with the team, ensuring the patient and partner approve the shared information. Laws about patients' rights to their charts are resulting in most systems having notes released automatically through the patient portal.

Therapists may encounter ethical issues about end-of-life decisions and advance directives. Couple therapists may also facilitate treatment plan negotiations, particularly when there is disagreement. Many other medical–ethical issues may arise in treating couples coping with controversial medical procedures, such as abortion, fertility treatments, transplantation, and genetic testing. Therapists themselves may need training or consultation to cope with these challenging issues, or at least a place to process their own reactions and feelings about them.

Research has shown that there is an advantage to engaging partners and family members in therapy to improve coping and self-management of serious and chronic illness (Rosland et al., 2012). Multiple models of family and couple therapies have developed an evidence base for their effectiveness. For example, emotion-focused couple therapy (see Chapter 6, in this volume, by Johnson et al.) and cognitive-behavioral couple therapies (see Chapter 3, also in this volume, by Baucom et al.) have been found to be helpful to couples facing chronic disease. Beyond the impact of specific forms of couple intervention, the role of attachment communication and level of dyadic coping have emerged as important aspects of couples functioning in couples facing medical issues. In addition, research continues to seek variables that help caregivers cope with the stresses of caregiving (Palacio et al., 2020).

CONCLUDING COMMENTS

It is not accidental that traditional Western marriage vows include the words "in sickness and in health." Illness is one of the most difficult challenges a couple can face. Couples coping with illness are often on an emotional roller-coaster ride, full of unexpected twists and turns. Couple therapists who take a biopsychosocial systems view of their work are in a unique position to help these couples cope. Although therapy for couples facing illness uses many skills from crisis intervention and transition-oriented therapies, medical family and couple therapy describes a framework for important skills and intervention principles specific to this work. When illness is a part of a couple's lives (even when it is not the stated presenting problem), it is critical that the therapist directly address issues related to the illness, including collaboration with relevant health professionals, learning about disease progression as it relates to functionality and behavior; providing specific psychoeducation; normalizing difficulties; and helping the couple find a sense of meaning, agency, and communion in the experience.

SUGGESTIONS FOR FURTHER STUDY

Falconier, M. K., Randall, A. K., & Bodenmann, G. (Eds.). (2016). *Couples coping with stress: A cross-cultural perspective.* New York: Routledge.

McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.

Rolland, J. S. (2018). *Helping couples and families navigate illness and disability: An integrated approach.* New York: Guilford Press.

Ruddy, N. B., Borresen, D., & Gunn, W. (2008). *The collaborative psychotherapist: How to create reciprocal relationships with medical professionals*. Washington, DC: American Psychological Association.

REFERENCES

Badr, H. (2017). New frontiers in couple-based interventions in cancer care: refining the prescription for spousal communication. *Acta Oncologica, 56,* 139–145.

Beil, H., Feinberg, R. K., Patel, S. V., & Romaire, M. A. (2019). Behavioral health integration with primary care: Implementation experience and impacts from the State Innovation Model round 1 states. *Milbank Quarterly, 97*(2), 543–582.

Berg, C. A., & Upchurch, R. (2007). A developmental–contextual model of couples coping with chronic illness across the adult life span. *Psychological Bulletin, 133,* 920–954.

Boparai, S. K. P., Au, V., Koita, K., Oh, D. L., Briner, S., Harris, N. B., & Bucci, M. (2018). Ameliorating the biological impacts of childhood adversity: A review of intervention programs. *Child Abuse and Neglect, 81,* 82–105.

Bryan, C. J., Morrow, C., & Appolonio, K. K. (2009). Impact of behavioral health consultant interventions on patient symptoms and functioning in an integrated family medicine clinic. *Journal of Clinical Psychology, 65,* 281–293.

Carek, P. J., Anim, T., Conry, C., Cullison, S., Kozakowski, S., Ostergaard, D., . . . Pugno, P. A. (2017). Residency training in family medicine. *Family Medicine, 49*, 275–281.

Click, B., & Regueiro, M. (2019). The inflammatory bowel disease medical home: From patients to populations. *Inflammatory Bowel Diseases, 25,* 1881–1885.

da Silva, F. M., Jacob, E., & Nascimento, L. C. (2010). Impact of childhood cancer on parents' relationships: An integrative review. *Journal of Nursing Scholarship, 42,* 250–261.

Dalteg, T., Benzein, E., Fridlund, B., & Malm, D. (2011). Cardiac disease and its consequences on the partner relationship: A systematic review. *European Journal of Cardiovascular Nursing, 10*(3), 140–149.

DeCaporale-Ryan, L., & Devine, M. (2019). *Essentials of multidisciplinary and transdisciplinary collaboration*. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Family therapy and training* (pp. 449–467). Washington, DC: American Psychological Association.

Doherty, W. J., & Baird, M. (1983). *Family therapy and family medicine: Toward the primary care of families*. New York: Guilford Press.

Ek, K., Ternestedt, B. M., Andershed, B., & Sahlberg-Blom, E. (2011). Shifting life rhythms: Couples' stories about living together when one spouse has advanced chronic obstructive pulmonary disease. *Journal of Palliative Care, 27,* 189–197.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129–136.

Falvo, D. R., & Holland, B. E. (2017). *Medical and psychosocial aspects of chronic illness and disability* (6th ed.). Burlington, MA: Jones & Bartlett Learning.

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process, 55,* 423–442.

Fu, F., Zhao, H., Tong, F., & Chi, I. (2017). A systematic review of psychosocial interventions to cancer caregivers. *Frontiers in Psychology, 8,* Article 834.

Goepfert, E., Mule, C., von Hahn, E., Visco, Z., & Siegel, M. (2015). Family system interventions for families of children with autism spectrum disorder. *Child and Adolescent Psychiatric Clinics of North America, 24,* 571–583.

Gonzalez, S., Steinglass, P., & Reiss, D. (1989). Putting illness in its place: Discussion groups for families with chronic medical illness. *Family Process, 28,* 69–87.

Harding, R., List, S., Epiphaniou, E., & Jones, H. (2012). How can informal caregivers in cancer and palliative care be supported?: An updated systematic literature review of interventions and their effectiveness. *Palliative Medicine, 26,* 7–22.

Hunter, C. L., Goodie, J. L., Dobmeyer, A. C., & Dorrance, K. A. (2014). Tipping points in the Department of Defense's experience with psychologists in primary care. *American Psychologist, 69,* 388–398.

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2016). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Hurley, K., Miller, S. M., Rubin, L. R., & Weinberg, D. (2006). The individual facing genetic issues: Information processing, decision-making, perception, and health-protective behaviors. In S. Miller, S. H. McDaniel, J. Rolland, & S. Feetham (Eds.), *Individuals, families, and the new era of genetics* (pp. 79–117). New York: Norton.

Jaiswal, J., & Halkitis, P. N. (2019). Towards a more inclusive and dynamic understanding of medical mistrust informed by science. *Behavioral Medicine, 45,* 79–85.

Katon, W. J., Lin, E. H., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., . . . McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine, 363,* 2611–2620.

Kearney, L. K., Post, E. P., Pomerantz, A. S., & Zeiss, A. M. (2014). Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: Transforming primary care. *American Psychologist, 69,* 399–408.

Kowal, J., & Johnson, S. M. (2003). Chronic illness in couples: A case for emotion-focused therapy. *Journal of Marital and Family Therapy, 29*(3), 299–310.

Martire, L. M., Schulz, R., Helgeson, V. S., Small, B. J., & Saghafi, E. M. (2010). Review and meta-analysis of couple-oriented interventions for chronic illness. *Annals of Behavioral Medicine, 40,* 325–342.

McDaniel, S. H., & Cole-Kelly, K. (2003). Gender, couples, and illness: A feminist analysis of medical family therapy. In L. B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy: Empowerment in social context* (pp. 267–280). Washington, DC: American Psychological Association.

McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.

McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: Basic Books.

Medialie, J. H. (1994). The caregiver as the hidden patient: Challenges for medical practice. In E. Kahana, D. E. Biegel, & M. L. Wykle (Eds.), *Family care giving across the life span* (pp. 312–330). Thousand Oaks, CA: SAGE.

Mehta, S., Peynenburg, V. A., & Hadjistavropoulos, H. D. (2019). Internet-delivered cognitive behaviour therapy for chronic health conditions: A systematic review and meta-analysis. *Journal of Behavioral Medicine, 42,* 169–187.

Mueller, K. L., Hudson, T. W., III, Bruns, D., Algire, D. Z., Buchta, W. G., Christian, J. H., . . . Vaille, W. C. (2020). Recommendations from the 2019 symposium on including functional status measurement in standard patient care. *Journal of Occupational and Environmental Medicine, 62,* e457–e466.

Nash, J., McKay, K. M., Vogel, M., & Masters, K. (2012). Functional roles and foundational characteristics of psychologists in integrated primary care. *Journal of Psychology in Medical Settings, 19,* 93–104.

National Center for Health Statistics. (2016). *Health, United States, 2015: With special feature on racial and ethnic health disparities.* Centers for Disease Control and Prevention. www.cdc.gov/nchs/data/hus/hus15.pdf.

National Institutes of Health. (2020). *National pain strategy.* www.iprcc.nih.gov/federal-pain-research-strategy/overview.

Palacio, G. C., Krikorian, A., Gómez-Romero, M. J., & Limonero, J. T. (2020). Resilience in caregivers: A systematic review. *American Journal of Hospice and Palliative Medicine, 37,* 648–658.

Parks, S. M., Winter, L., Santana, A. J., Parker, B., Diamond, J. J., Rose, M., & Myers, R. E. (2011). Family factors in end-of-life decision-making: Family conflict and proxy relationship. *Journal of Palliative Medicine, 14,* 179–184.

Petrie, K. J., & Jones, A. S. K. (2019). Coping with chronic illness. In C. D. Llewellyn, S. Ayers, C. McManus, S. Newman, K. J. Petrie, T. A. Revenson, & J. Weinman (Eds.), *The Cambridge handbook of psychology, health and medicine* (pp. 110–114). Cambridge, UK: Cambridge University Press.

Porter, L. S., Fish, L., & Steinhauser, K. (2018). Themes addressed by couples with advanced cancer during a communication skills training intervention. *Journal of Pain and Symptom Management, 56,* 252–258.

Prochaska, J. O., Velicer, W. F., Redding, C., Rossi, J. S., Goldstein, M., DePue, J., . . . Plummer B. A. (2005). Stage-based expert systems to guide a population of primary care patients to quit smoking, eat healthier, prevent skin cancer, and receive regular mammograms. *Preventive Medicine, 41,* 406–416.

Robinson, C. A. (2017). Families living well with chronic illness: The healing process of moving on. *Qualitative Health Research, 27*(4), 447–461.

Rolland, J. (1994). *Families, illness, and disability: An integrative treatment model.* New York: Basic Books.

Rolland, J. S. (2018). *Helping couples and families navigate illness and disability: An integrated approach.* New York: Guilford Press.

Rosland, A. M., Heisler, M., & Piette, J. D. (2012). The impact of family behaviors and communication patterns on chronic illness outcomes: A systematic review. *Journal of Behavioral Medicine, 35,* 221–239.

Ruddy, N. B., Borresen, D., & Gunn, W. (2008). *Working together: The psychotherapist's toolbox for collaborating with medical professionals.* Washington, DC: American Psychological Association.

Smith, S. M., Li, R., Wolfe, H., Swanger-Gagne, M. S., Bonham, A. D., Kreher, D. A., & Poleshuck, E. L. (2019). Couple interventions for chronic pain. *Clinical Journal of Pain, 35,* 916–922.

Suso-Ribera, C., Yakobov, E., Carriere, J. S., & García-Palacios, A. (2020). The impact of chronic pain on patients and spouses: Consequences on occupational status, distribution of household chores and caregiving burden. *European Journal of Pain, 24,* 1730–1740.

Swallow, V., Macfadyen, A., Santacroce, S. J., & Lambert, H. (2012). Fathers' contributions to the management of their child's long-term medical condition: A narrative review of the literature. *Health Expectations, 15,* 157–175.

Tai, D. B. G., Shah, A., Doubeni, C. A., Sia, I. G., & Wieland, M. L. (2021). The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. *Clinical Infectious Diseases, 72,* 703–706.

Traa, M. J., De Vries, J., Bodenmann, G., & Den Oudsten, B. L. (2015). Dyadic coping and relationship functioning in couples coping with cancer: A systematic review. *British Journal of Health Psychology, 20,* 85–114.

Tsai, P. F., & Jirovec, M. M. (2005). The relationships between depression and other outcomes of chronic illness caregiving. *BMC Nursing, 4,* Article 3.

Usuba, K., Li, A. K. C., & Nowrouzi-Kia, B. (2019). Trend of the burden of chronic illnesses: Using the Canadian Community Health Survey. *Public Health, 177,* 10–18.

Van Houtven, C. H., Hastings, S. N., & Colón-Emeric, C. (2019). A path to high-quality team-based care for people with serious illness. *Health Affairs, 38,* 934–940.

Vig, K. D., Paluszek, M. M., & Asmundsen, G. J. G. (2020). Adverse childhood experiences and physical health outcomes. In G. H. J. Amundsen & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy and prevention* (pp. 71–90). London: Academic Press.

Watson, W. H., & McDaniel, S. H. (2005). Managing emotional reactivity in couples facing illness: Smoothing out the emotional roller coaster. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 253–271). Hoboken, NJ: Wiley.

White, N., & Newman, E. (2016). Shared recovery: Couples' experiences after treatment for colorectal cancer. *European Journal of Oncology Nursing, 21,* 223–231.

SPECIAL TOPICS

CHAPTER 29

Relationship Enhancement and Distress Prevention

Ryan G. Carlson, Galena K. Rhoades, Sabrina Johnson, Scott M. Stanley, and Howard J. Markman

BACKGROUND

Relationship education is a skills-based, psychoeducation approach to addressing healthy relationships. Relationship education began in the early 1900s, largely in faith-based circles, as a means to help premarital couples address issues they might face later in marriage, as well as issues that are known to create challenges for couples. It was not until the 1980s that family scientists began studying the effectiveness of secular premarital and marital enrichment programs (Markman & Floyd, 1980). The primary aim of early enrichment programs was to prevent later relationship problems during marriage. Today, relationship education is similar to early enrichment programs in that the content is generally implemented universally to couples regardless of their specific presenting concerns (i.e., no triage or adaptations based on specific couple issues or levels of distress). As such, relationship skills-building programs may reduce the stigma associated with traditional therapy and increase the likelihood that couples will participate (Markman & Ritchie, 2015).

Relationship education has continued to evolve over the past four decades and is substantively different than traditional couple therapy in that it (1) typically involves a manualized curriculum; (2) is often implemented in a workshop-style environment (although, there are some exceptions that we discuss later in this chapter); (3) focuses on skills and strategies to reduce risks and increase protective factors rather than on problems presented by couples; and (4) may be taught by laypersons who are certified, or specifically trained, by the curriculum developers. While still available in faith-based organizations today, relationship education has expanded beyond religious affiliations and is now widely utilized in mainstream and secular environments. Before discussing relationship education further, we note that there are various titles used to describe relationship education, such as marriage and relationship education, couple and relationship education, and relationship enhancement. While there is currently no consensus in the field about which title to use, we use the term "relationship education" in this chapter to represent the broad field that has developed since the initial inception of relationship skills-building approaches. For example, relationship education is now implemented with numerous subgroup populations, including those attending individually or in same-gender relationships and in a variety of formats, including in-person workshops, online (asynchronous, self-paced), self-directed training, virtual (synchronous, live) workshops, or as an adjunct within traditional therapy settings. In this chapter, we aim to (1) provide a brief overview about the background of relationship education, including federal funding in the United States; (2) present some example curricula and common core elements across curricula; (3) discuss practical considerations in providing relationship education; (4) describe treatment applicability, including adaptations based on culture, race, and ethnicity; and (5) summarize empirical support.

The use and availability of relationship education in the United States received a large boost when, in 2005, the U.S. federal government began allocating $150 million per year to support healthy marriage and responsible fatherhood programs, with the overall aim of improving child outcomes based on supporting parental relationship stability. Funding allocations have been made through the Administration for Children and Families, Office of Family Assistance, and have resulted in roughly 2.5 million people receiving relationship education services. Government support of relationship education is not unique to the United States. For example, Australia, Germany, Singapore, Qatar, Denmark, Norway, Estonia, Tiawan, and the United Kingdom have all invested in relationship education programs to support healthy relationships.

RELATIONSHIP EDUCATION PROGRAMS AND COMMON CORE ELEMENTS

Common Core Elements

There are many relationship education curricula available to use with couples, and some specifically for individuals attending on their own, or without a partner. Many curricula have been developed by scholars or clinicians in family science disciplines. The curricula vary based on theoretical underpinnings, training requirements, modality (online versus face-to-face), and intended audience. The Marriage Strengthening Research and Dissemination Center (MAST) conducted an overview of relationship education through Child Trends, funded by the Administration for Children and Families (Scott & Huz, 2020). Their review is limited to curricula that have been used by U.S. government-funded programs but serves as a guide for practitioners or community agencies when comparing and considering various curricula to implement. Key findings in the MAST brief are as follows: Many of the curricula have been updated to include subpopulations despite not originally being designed for these populations (e.g., low-income; military); topics included in the curricula align with the intended target population, but all typically address strategies for effective communication and healthy conflict management; more research is needed to support specific curriculum mechanisms of change (i.e., what specifically helps couples improve); and there are not consistent training standards for use with each curriculum. The primary consistent focus of most curricula is to improve communication and conflict resolution skills. Some curricula discuss other topics, such as commitment, healthy relationship development, or forgiveness. But these topics are less prevalent and likely more specific to the theory driving the curriculum development.

In our own review of relationship education curricula, we found that some include empirical support, and most are designed for couples to attend together. Additionally, training standards vary widely, with many indicating no standards at all. Few curricula include an option for online implementation, with the remaining intended for face-to-face delivery. Below, we highlight select curricula within the context of three different relationship education formats (couples, individuals, and online) and focus specifically on those that have empirical support and have been culturally adapted and implemented globally.

Face-to-Face, Couple-Oriented Relationship Education

In couple-oriented relationship education, partners are invited to attend together. Although it is possible that one member of a couple may miss a meeting, the other member is still invited to attend. Additionally, makeup sessions, or makeup work, may be offered to the partner who missed the session. The goal here is that couples are experiencing the curriculum material together and may practice together the new skills learned. Some examples of well-known research-based couple-oriented curricula are the Prevention and Relationship Education Program (PREP), PREPARE/ENRICH, and Hold Me Tight.

Prevention and Relationship Education Program

PREP (*prepinc.com*; Markman, Stanley, & Blumberg, 2010) is based on social learning theory, emphasizes intentionality in relationship development, and teaches specific skills to communicate and resolve conflict in a healthy manner. PREP also addresses emotion regulation (i.e., managing emotions), relationship commitment, expectations, intimacy, and relationship safety. PREP is available in several formats and can vary in length and program format. For example, the latest version, PREP 8.0, is a 12- to 15-hour curriculum that comprehensively addresses relationship issues. The program can be adapted and provided in shorter options, such as a 1-day (8 hour) workshop and even a 2-hour version. PREP and a variant, Within Our Reach, have been used widely by those implementing community-based relationship education. Jakubowski, Milne, Brunner, and Miller (2004) noted that PREP is one of only a few curricula with a strong history of research support. PREP has also been adapted and implemented in many European as well as non-Western countries.

PREP training for leaders/practitioners is available either online or face-to-face, and requires about 3 days to complete. Once trained in PREP, leaders can implement workshops in a variety of formats, as PREP provides flexible delivery methods and topics. A popular delivery method typically involves facilitating a group-style workshop during the evening, over the course of three or four evenings, one evening a week, or two consecutive weekends. Although the exact duration and specific topics can vary based on the unique context and setting, the hallmark of PREP includes teaching tools such as three keys to healthy relationships, the speaker–listener technique, and the identification and clarification of expections. The three keys include (1) Do your part, (2) Make it safe to connect, and (3) Decide, don't slide. The three keys are typically addressed early to help participants remember core principles of action that serve as a foundation for the training in various skills, strategies, and themes to strengthen couple relationships.

A hallmark of PREP is an underlying belief that people tend to handle difficult emotions or issues best with more structure, and that structure can promote emotional safety. The central example of this principle is the speaker–listener technique, which is a communication strategy that provides a structured approach for couples to communicate in a straightforward manner, without blaming, and encouragement of active listening. In other word, couples learn how to talk without fighting about important relationship issues and how to support each other through difficult times. At any given moment when using the technique, each member of the couple is in either the role of speaker or listener, with an object denoting the "floor," indicating who is in what role. The floor is typically a card with the rules for the technique on it. The couple is trained to switch the floor back and forth as needed over the course of a conversation. The speaker–listener technique has two functions. First, it provides a structured way for couples to practice basic speaking and listening skills, as well as turn taking. With practice, most couples can engage the skills in a far less formal process over time. Second, couples learn that adding structure to difficult or important conversations can increase the odds of both partners feeling heard, with lower risk for negative communication. Thus, couples can always more fully "engage" the more structured model for an important conversation.

PREP also teaches couples how and when to take a time-out, a four-step model for problem solving, and how to identify and share expectations. Additonal themes focus on protecting and enhancing positive connections (fun, friendship, sensuality) and on understanding and acting on commitment.

Like other relationship education curricula, PREP uses a combination of didactic instruction, video demonstrations, and experiential opportunities for participants to practice the skills they learned. PREP facilitators are less concerned about the specific topics that couples discuss, and more concerned with skill application. Participants receive a workbook to write down responses and follow the material being presented. PREP encourages the use of coaches who can provide couples with more one-on-one support as they practice the skills they are learning. Coaches actively participate in the workshops by walking around the room to support couples individually as they practice the skills, or coaches may schedule separate meetings with couples (telephonically or virtually) at predetermined times to discuss how the couple is doing with the skills, and support them in unique ways. Coaches are not conducting therapy, nor do they need to be trained therapists, but instead are focusing on supporting skill implementation. Coaching is not unique to PREP, but it is strongly encouraged by the PREP team as there is empirical support for the use of coaching in relationship education.

PREPARE/ENRICH

The PREPARE/ENRICH program *(prepare-enrich.com*; Parrott, Parrott, & Olson, 2021*)* is unique in that it specifically addresses couples in various life stages. For example, a version is included for couples who are thinking about marriage (premarital), as well as those who are already married and have children, or are cohabiting. This program also includes a couple personality profile that provides a comprehensive overview and assessment of the couple's strengths and identifies areas for improvements. The program addresses couple issues such as communication skills, conflict resolution, finances, dealing with stress, and providing a family map that addresses family-of-origin influences on the relationship. In total, there are between 8 and 10 hours of content, but the delivery method is flexible and can be adjusted as needed. For example, this curriculum can be delivered in a group format over the course of several weeknights or in a weekend style retreat. This material may also be implemented in one-on-one sessions with a trained psychotherapist. PREPARE/ENRICH includes research supporting the validity of the personality measure and curriculum content. PREPARE/ENRICH has been translated into numerous languages as well.

Hold Me Tight

The Hold Me Tight curriculum (*holdmetightonline.com*; Johnson, 2008) is based on the research-supported, emotion-focused couple therapy approach (see also Chapter 6 on "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan). Curriculum topics focus on identifying destructive remarks, learning to look beyond immediate reactions to identify raw spots, deescalating conflict and building emotional safety, increasing emotional responsivity and connection, forgiveness, emotional connection through sex, and learning to be mindful to maintain the connection. Hold Me Tight and emotionally focused couple therapy are based on attachment theory, which posits that people need to be in relationship with others, and that one's early attachment experiences to a caregiver influence later adult relationships. As a result, couples need to understand this influence in order to make changes. This program is 16 hours long and is typically provided in eight 2-hour sessions. There is no formal training for this curriculum, but most facilitators are trained in emotionally focused therapy. In addition to research support for emotionally focused couple therapy, the Hold Me Tight curriculum has been translated to several languages other than English.

Online, Couple-Based Relationship Education

Two evidence-based curricula are available for couples to complete entirely online: OurRelationship and ePREP. Both programs have been adapted from other models, and both have strong research supporting their effectiveness with low-income and distressed couples (Doss et al., 2020). Online curricula mitigate many of the challenges that prevent couples, especially those with low income, from seeking couple therapy or face-to-face relationship education. For example, couples do not need to worry about child care, transportation, or issues related to scheduling (e.g., shift-style schedules that vary weekly). Online programming may also mitigate the stigma of relationship help that sometimes prevents couples from seeking help altogether (see also Chapter 30, "Telehealth and Digital Couple Interventions," in this volume, by Doss, Knopp, Wrape, & Morland). During the COVID-19 pandemic, many U.S. government-funded programs transitioned from face-to-face to online programming and used these online curricula. In addition to the previously mentioned benefits of online relationship education, there are some potential limitations to consider. For example, the two curricula we describe below are implemented asynchronously, meaning that couples progress through the material on their own. Thus, couples do not meet other couples, and miss out on the possible benefit of hearing others share about their relationships as they would if they participated in a traditional workshop. Moreover, couples may miss out on the benefit of the quality time spent together when attending traditional relationship education workshops together. Despite these potential limitations, the benefits in terms of convenience and autonomy provided by receiving such interventions online are significant. Furthermore, both programs can optionally be implemented with brief coaching support by practitioners or relationship educators in order to improve retention and learning. There is flexibility surrounding how to implement either program, including as stand-alone training for couples or adjuncts to relationship education workshops or couple therapy.

OurRelationship

OurRelationship (*ourrelationship.com*; Doss et al., 2020) is a 4- to 6-week online program designed as a secondary prevention intervention; that is, the OurRelationship program helps couples address existing problems in the relationship before they become too problematic (see also Chapter 30, in this volume, by Doss et al.). OurRelationship is based on integrative behavioral couple therapy (see also Chapter 4, "Integrative Behavioral Couple Therapy," in this volume, by Christensen, Dimidjian, Martell, & Doss) and incorporates the importance of emotional acceptance while addressing topics such as communication, emotional distance, trust, infidelity, and resolving arguments. The online lessons are delivered with videos and supported by coaching calls. The program is available in both English and Spanish, and requires a 6-hour training with additional ongoing supervision in order to provide this approach to couples. OurRelationship is a unique approach to relationship education not only because of its sophisticated online platform but also because couples can choose to focus on a specific problem. As such, they are able to tailor the material to their specific relationship issue. OurRelationship has empirical support with couples and is effective with couples who are actively seeking help, and who are therefore likely relationally distressed (Doss et al., 2020). There are protocols for providing the optional brief coaching to couples going through OurRelationship.

ePREP

ePREP (*lovetakeslearning.com*; Braithwaite & Fincham, 2009) is a self-paced, adapted version of PREP. ePREP comprises about 8 hours of curriculum content that focuses on the major PREP concepts of healthy communication, effective conflict resolution, relationship safety, and commitment. Couples complete the content by progressing through a series of modules in a certain order. There is no specific training for ePREP, but those implementing this program for their couples with the optional coaching model should get the training PREP provides for doing this most effectively. There is flexibility surrounding how to implement ePREP, but for ePREP (as for OurRelationship), providing ongoing support to couples as they progress through the content is beneficial. Furthermore, use of the brief coaching model gives an opportunity for providers to build rapport with the couples they serve.

Individual-Oriented Relationship Education

Individual-oriented relationship education is intended for people to attend without their partner, including individuals who are not currently in a relationship or those who are not in a stable relationship. As such, in addition to relationship skills training, these curricula focus on healthy relationship development and may address more sensitive topics, such as domestic violence, that might be more challenging, or not safe, to address with both members of the couple in the room (Rhoades & Stanley, 2011). In comparison to couple-oriented relationship education programs, not as many studies have been conducted on individual-oriented relationship education, but among those that were conducted, attendees improved on individual distress symptoms (Carlson, Rappleyea, Daire, Harris, & Liu, 2017) and parenting (Carlson, Dillman Taylor, Barden, Olejarczyk, & Glascoe, 2021). The potential implementation benefits to individual-oriented relationship education are that scheduling challenges may be mitigated by navigating the schedule of one person as opposed to two people. Additionally, when targeting only one person, there is not a reliance on the other person to be a willing participant. Furthermore, there are many situations in which individuals are either not in committed relationships or healthy relationships, but they may be interested in relationship education that can help them with their relationship decision making, goals, and skills. Some attendees may also be interested in learning skills they can share with extended family members. However, fewer curricula have been adapted for individual attendees. We briefly describe two below.

Within My Reach

Within My Reach (*prepinc.com*; Pearson, Stanley, & Rhoades, 2008) "is a relationship skills and decision making program for helping individuals achieve their goals in relationships, family, and marriage" (p. 1). It is a flexible, 15-hour curriculum, which means that content and length can be adapted depending on the context and setting of the target audience. The recommended dosage is between 8 and 18 hours, and format can vary from 1 day (8 hours) to 6 weeks (approximately 3 hours per week). Within My Reach is built around two fundamental principles: The first is that people aspire to have happy, healthy, and stable relationships; the second is that relationship decisions affect success in all other areas of life. The primary aims of Within My Reach are to (1) help those in viable relationships to cultivate, protect, and stabilize their unions, and to marry if desired; (2) help those in damaging relationships to leave safely; or (3) help those who desire a romantic relationship to choose future partners wisely (Pearson et al., 2008).

Within My Reach sample curriculum topics include teaching participants about healthy relationships; the concept of sliding versus deciding; dangerous patterns in relationships (including intimate partner violence); conflict; the speaker–listener technique; infidelity; commitment; and making tough decisions (deciding to stay or leave a relationship). Many of these topics are derived from PREP but also represent the unique Within My Reach focus on healthy relationship decision making for individuals. Thus, individuals attending Within My Reach learn about how to choose a partner well, helping to ensure symmetrical commitment, intentional decision making, and high levels of dedication to the relationship. Individuals who attend Within My Reach, but are in a current relationship, may develop an awareness about the health of their current relationship. As a result, some attendees may realize they are not in a healthy relationship. Success in relationship education programs, specifically, individual-oriented relationship education, cannot solely be assessed by whether couples stay together, as some may choose to leave unhealthy relationships.

Within My Reach has been tailored for individuals who have struggled with economic disadvantage. The curriculum has been used in various settings and populations, such as individuals in community agency settings, university centers with youg adult students, as well as programs serving victims of domestic violence. Within My Reach is available in English and Spanish. Implementation is similar to other PREP models, in that a combination of didactic presentations using PowerPoint, video demonstrations, discussion, and experiential practice are used. Because of the individual nature of Within My Reach, there are additional opportunities to implement the curriculum with broader audiences, such as partnering with local schools to offer the workshops to individual parents of children, or with local correctional facilities to help those incarcerated learn more about healthy relationship skills and development that can be applied upon their release.

Premarital, Interpersonal, Choices and Knowledge (PICK) a Partner

PICK (*mylovethinks.com*; Van Epp, 2007) is intended for singles as young as middle school to elderly people. PICK teaches relationship development, such as pacing the relationship, and teaches participants to identify five things to know about a partner that can predict what they will be like in a relationship. Thus, the emphasis is on starting a healthy relationship for attendees who are not currently in a relationship. The content is available in several languages and is typically taught in lectures with videos and discussion. The total length of the content is 8 hours, and it is taught in 90-minute sessions. There is no formal training required, but potential facilitators are encouraged to attend a live seminar, or they can review the online instructor certification packet and pass the test.

CONSIDERATIONS IN PROVIDING RELATIONSHIP EDUCATION

Relationship education can be provided as a stand-alone intervention, as an adjunct to couple therapy, or the curriculum skills can be integrated into a traditional couple therapy treatment plan. Following, we discuss considerations for implementing relationship education, with a special focus on integrating the service into therapy practice.

Selecting a Curriulum

Selecting a relationship education curriculum begins with consideration of the target population. For example, communities near military bases likely comprise a large number of current or former military service personnel and their families. Choosing a curriculum that has been adapted for military families would then be important. Additional considerations could be made, bearing in mind the cultural composition of the community, socioeconomic status, or urban versus rural communities. Each dynamic may influence which curriculum is chosen (e.g., translation to the desired language, or cultural adaptation—we say more about this later), and how the curriculum is delivered (e.g., online vs. face-to-face, in-home, or center-based). We recommend consulting directly with the curriculum developers, who may be able to provide further guidance based on many of these factors.

Another consideration in choosing a curriculum is the cost to be trained and the training standards. Whereas some curricula training requirements may include several days worth of training but also provide ongoing technical support options, others may include less formal training standards but not provide much support after becoming trained. If providing relationship education on a frequent basis, and to large numbers of couples or individuals, working with an established curriculum developer that can provide ongoing technical support is an added resource.

Curriculum developers also vary in the supplemental materials that are available for facilitators and participants, as well as the expediency with which they can provide any available materials upon order. Relationship education participants likely appreciate having a workbook to complete, as well as any supplements, such as wallet cards or refrigerator magnets, that might help quickly remind them about the tools they are learning. Such supplements can also be helpful to facilitators when teaching the skills. In addition to workbooks, PowerPoint slides and video demonstrations are also useful tools when teaching relationship education skills. These supports are not available for every curriculum.

Community Partners

Many of the organizations that have successfully implemented relationship education have done so with the support of strong community relationships. The partnerships may include providing referrals to receive relationship education, referral sources for those attending relationship education who may need additional supports, or providing a physical space to offer the relationship education workshops. Integrating relationship education as a community initiative may help expand the overall reach and availability of services, improve the quality of supports provided, and enhance trust for attending participants. For example, in some rural communities, churches are trusted organizations with a vested interested in the health of their congregants' relationships. Thus, partnering with a church or synagogue to offer relationship education may help increase the trust that participants have in the service being provided. Additionally, the religious organization may be able to help with important logistics, such as providing child care or even offering meals during or after the workshops (we say more about this later).

Other community partnerships may include domestic violence or mental health agencies. Issues such as substance use or severe mental health problems, left active and untreated, have the potential to undermine any positive relationship skills participants learn through relationship education interventions. In some instances, such as intimate partner violence, relationship education skills could inadvertently create additional safety concerns in the relationship. For some participants, finding relationship supports and accessible interventions is not easy, and immediately referring out of those services due to concerns about intervention appropriateness can be demoralizing for couples that took steps toward receiving support. Thus, working with partners to establish constructive and safe protocol to address such scenarios is important.

Logistics

Along with deciding on a curriculum and acquiring community partnerships, one also needs to decide on several logistics that may be influenced by both the curriculum and community partnerships. Relationship education can be offered during weekend retreat-style workshops, ongoing weeknight psychoeducation groups, online, or as a supplement to traditional therapy. Each format includes unique additional considerations, as well as overlapping considerations. We address some of the unique considerations first, then conclude with the overlapping considerations.

Face-to-Face Workshops

Providing relationship education to couples in a workshop format requires a location large enough to hold a predetermined group of couples, includes technology support, is easy for couples to find, and has space for onsite child care, if provided (highly recommended). Additionally, an intake and enrollment process should be included that considers couples' availability to attend the workshop. A process for addressing how to handle situations when couples cannot attend a regularly scheduled workshop should also be given consideration. For example, will the couple be provided with a makeup session, then continue with the next scheduled workshop? If offering a makeup session, will this occur face-to-face, virtually, or telephonically? We suggest providing as many options as possible for couples to make up any missed content, so that participants have an opportunity to receive as much of the content as possible.

Face-to-face workshops typically include a cofacilitator team. Facilitators can be laypersons who are not trained as therapists. They should be trained in the curriculum, have received training on general group facilitation skills, and receive ongoing supervision/support to ensure curriculum fidelity and manage group dynamics. We have seen successful approaches to facilitating workshops when the facilitators are representative of the participants attending the workhops. For example, if the primary target audience is Latino/a, then having at least one Latino/a facilitator may help participants feel more represented and improve rapport with the facilitators. In addition to workshop facilitators, coaches who can follow up with workshop participants at regular intervals to provide tailored curriculum support may help couples better integrate the skills they are learning.

Online

We briefly discuss online approaches because these are addressed more thoroughly in Chapter 30, in this volume, by Doss and colleagues. However, in the specific context of relationship education, online approaches should consider how participants will access the online material. If the curriculum includes a mobile-friendly platform, this may mitigate any concerns about broadband access that would be required for nonmobile friendly platforms. Additionally, because online curricula can be implemented asynchronously (i.e., participants complete the curriculum material at their own pace), it is important to consider how couples will receive additional support as they integrate the skills learned. Conducting regular follow-up calls with participants to process their experience and review the skills is exceptionally important for online programs.

Not all online programs are asynchronous. Many relationship education providers now offer synchronous, live, online workshops. This live web group format not only includes the benefits of attending online but also provides a chance for couples to learn from others and ask the workshop facilitators direct questions. Additionally, there are no online adaptations needed, as this approach can be used with any curriculum. That said, facilitators should be mindful of minor adjustments that might aid in implementation, such as creating time for more frequent breaks.

Integration into Traditional Therapy

Relationship education is a flexible intervention that can be implemented in a variety of ways, including integration into traditional couple therapy modalities. The specificity and structure of relationship education tools provide a "label" to couple interactions. Many times, couples state they were already using the "new tool" but did not know what to call it. Providing a name to the interaction may help them replicate the skill during a time when things are not going as well. Relationship education can also be considered a secondary prevention method with couples who have been struggling with issues or are distressed. Distressed couples enroll in relationship education or couple therapy, often depending on the intervention they find first, or the one that is more feasible. Moreover, many relationship education skills developed from couple therapy approaches. Thus, a fluid boundary exists between the two intervention modalities. Couples may appreciate not only the psychoeducational nature of the relationship education curriculum material but also the structure of the skills. Couples who have been struggling with the same issue over a long period of time often engage in a negative communication pattern. The structure associated with relationship education skills may help those couples successfully navigate a conversation about the problem issue, resulting in hope about the future of the relationship.

Relationship education skills can be used to provide couples with specific ground rules for therapy. For example, PREP's speaker–listener technique offers a structured method for communicating about an issue. This can be particularly helpful to couples who have struggled to stay on track while discussing specific issues. Integrative approaches to couple therapy may be conducive to including specific tools from relationship education curricula. The therapist can choose a specific relationship education tool that is appropriate given the couple's primary presenting problem and their therapy goal. The therapist should describe the tool to the couple, teaching them the primary goal of the tool and how to use it. The therapist may act as a coach while the couple is practicing the skill in order to help them use the tool constructively. The couple can be encouraged to practice the skill between therapy settings, then report back on their experiences with using the skill at home.

A primary difference between offering relationship education in a workshop setting and therapy is that the material is presented universally to couples attending a workshop; that is, all couples receive the same content and learn the same skills despite their reasons for attending the workshop (or primary presenting concerns). However, if relationship education skills are being taught in a therapy setting, the therapist can integrate the skills into a treatment plan and choose to teach the specific skills that may be more tailored to the couple's presenting problem and their ultimate goal for therapy.

Markman and Rhoades (2012) noted additional features of therapists incorporating relationship education into their clinical practice with couples, such as using relationship education workshops as a supplement to traditional couple therapy. For example, a therapist providing couple therapy may also recommend that the couple attend a weekend workshop conducted with a trusted partner who is using an evidence-supported relationship education curriculum. This provides couples with the opportunity to learn from others, reinforce any skills being learned in therapy, and hear about additional resources in the community. As Markman and Rhoades noted, therapists who choose to also implement relationship education workshops have the potential to increase their impact on couples in the community because they can treat more couples than through traditional therapy alone.

Overlapping Considerations

RETENTION

There are overlapping considerations that transcend the relationship education delivery method. Of primary concern is retaining couples, so that they complete enough of the intervention to allow for positive relationship improvements. Of course, dosage is a concern for any therapist providing treatment, but retention efforts have been a primary focus for programs implementing relationship education. Successful retention strategies are founded on an understanding of the challenges couples experience while remaining engaged and completing the intervention. For example, relationship education has been successfully implemented with low-income couples because programs have developed strategies to help couples navigate the unique challenges they experience to program completion. Low-income couples often work shift-style jobs, which makes consistent attendance over the course of several weeks difficult. Thus, providing flexible options to make up missed content helps these couples to remain engaged. Providing onsite, and quality, child care and meals at each workshop also supports long-term attendance for couples with few resources.

Retention results are often the product of the rapport established with couples and participants. Emphasizing rapport-building strategies is vital to retaining clients. In our experience, women tend to initiate participation more than do their male counterparts. To address any concerns a male partner, or the noninitiating partner, may have, we suggest speaking with both partners prior to enrolling in the intervention. This may help both partners feel included in the process. Another retention strategy is to simply ask couples at the end of each workshop about their intentions to return to the next scheduled workshop. Carlson, Wheeler, and colleagues (2021) studied the impact of asking couples this question and having them rate their responses on a 5-point Likert scale from 0 (*not at all likely to return*) to 5 (*highly likely to return*). Responses did predict retention, and responses of less than a 5 were specifically predictive of nonattendance. Using a scale like this, then following-up with couples who indicated less than a 5 is one practical strategy to retaining couples, while also helping to address any proactive issues that might prevent them from continuing in the program.

Retention can also be informed by appropriate screening strategies for relationship education interventions. Intake and enrollment processes should include screening for overall relationship quality, individual distress, and needs/resources. Screening for couples' relationship quality can include questionnaires that assess for their overall levels of relationship satisfaction, couple communication, and relationship commitment. Additionally, we think it is helpful to understand how individuals are coping with general psychological functioning, such as anxiety, stress, and depression, as these all correlate highly to relationship functioning. A basic needs assessment should also be included during the enrollment process to help identify immediate needs with housing, financial assistance, employment, or other areas of functioning that could be influencing relationship functioning. Many relationship education programs include these outside influences as topics of discussion and consideration in their curricula content, and several programs have successfully implemented ancillary supports to help provide couples with referrals to community resources. Some resources may help support additional mental health needs that are not treated in relationship education. Other needed resources might include career-related services, financial services, or parenting support.

INTIMATE PARTNER VIOLENCE

In addition to more general relationship conflict, many couples who attend relationship education report some type of intimate partner violence (IPV; see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich). The prevalence of couples who experience some form of IPV and attend relationship education is relatively high, with some estimates as high as 39% (Halford, Petch, Creedy, & Gamble, 2011). Government-funded relationship education programs have partnered with local and national domestic violence experts to address and develop detailed protocols for managing IPV disclosures. These protocol and screening procedures represent collaborative and multidisciplinary informed practices that aim to keep a victim's safety at the center of treatment decisions. Relationship education is considered a safe intervention for couples navigating low levels of IPV because participation is voluntary, program length is typically shorter in duration, and couples are learning concrete skills to help them resolve conflict in a healthier manner. Relationship education has shown promise in reducing IPV among couples who attended (e.g., Roddy, Georgia, & Doss, 2017). However, there is no clear and universally accepted method to screen and address IPV in couples who present for couple therapy or relationship education (see Stanley et al., 2020). The identification of IPV typologies has advanced our understanding of how IPV can vary among couples, but the danger of IPV-related behaviors remains high for victims. Yet doing nothing for couples does not seem helpful either. Thus, relationship education, as an educational and skills-based approach, may be an alternative intervention strategy.

Challenges to Consider

There are some noteworthy challenges when providing relationship education, including decisions about how to handle couple conflict during a relationship education workshop group meeting, deciding what to do if only one member of a couple shows up for a couple-oriented group workshop, or addressing appropriate boundaries between couples in the group, as well as among facilitators and couples. We begin with the issue of couple conflict during the group workshops. Conflict is inherent in every couple relationship, but teaching couples to manage conflict in a healthy way is a primary relationship education goal. Thus, conflict during the workshops presents an opportunity to help couples use the skills to successfully navigate the conflict, but not while serving as a distraction to other couples, or when the couple is engaging in a harmful cycle of communication. Asking the couple to take a time-out may help them cool down. Relationship education programs, like PREP, recommend that couples start practicing the tools by addressing minor issues, so that they can build positive momentum. In more extreme conflict scenarios, the couple may be asked to step outside the room, receive individual consultation from the facilitator, and return once they feel ready to reengage. Relationship education should be an opportunity to do conflict better and should not encourage or reinforce maladaptive patterns.

If only one member of a couple attends a couple-based workshop, we recommend allowing that person to stay without their partner. Given the many challenges that couples face to attending relationship interventions, we think it is important to honor that struggle by allowing the person who could attend the session to stay. Moreover, there are relationship benefits to the couple when one member attends and learns new skills that they share with their partner. Unlike traditional therapy, there is less concern about an alliance with the therapist or triangulation when only one member of the couple is able to attend. The absent partner should also be offered an opportunity to make up the content but not precluded from moving forward if the makeup cannot be arranged.

Another important decision is considering when to provide a relationship education group tailored to one demographic versus including diverse couples together. An example is whether to provide relationship education to same-gendered couples separately or including mixed-gendered couples with them. There is empirical support indicating that both same-gendered and mixed-gendered couples benefit from universal relationship education, but there is also support for tailoring relationship education to address unique considerations for same-gendered couples (we address such considerations more in the "Adaptations to Specific Populations" section). Moreover, when providing relationship education in a group setting, couples from various backgrounds and with different beliefs and values are often involved in the group together. More often than not, couples benefit from the diversity of thought and sharing that occurs. However, there are times when one person may try to influence other couples with their values. Facilitators should skillfully redirect when this happens, and if clear ground rules were established at the beginning of the workshops, facilitators should remind couples of the ground rules to always respect other couples.

There are some additional ethical considerations for relationship education implementation that may mirror considerations for traditional couple therapy. Examples include suspicions of child or elder adult abuse/neglect, or harm to others, and how and when to report such suspicions. Consultation with peers or curriculum developers can be helpful when deciding how to navigate such circumstances.

TREATMENT APPLICABILITY AND EMPIRICAL SUPPORT

Treatment Applicability

Early in the evolution of relationship education, programs targeted couples before marriage with premarital education programs. Couples discussed issues such as religion, finances, and parenting in the hope that they would address any potential sticking points prior to getting married. The primary access point for couples was through faith-based organizations. Scholars studying the effects of premarital programs found that couples who attended were less likely to divorce after marriage (Stanley, Amato, Johnson, & Markman, 2006). Approximately 38% of U.S. couples receive either premarital or early marital interventions of some kind (White, Duncan, Yorgason, James, & Holmes, 2020), and those who attend premarital education are more likely to seek marital therapy when later problems occur (Williamson, Trail, Bradbury, & Karney, 2014). However, early premarital and relationship education programs served primarily White and middle-upper-income couples. An influential motivation behind the vast U.S. federal support for relationship education programs was to diversify access to relationship skills-building and improve outcomes for children by supporting healthier relationships for their parents.

Couples who attended relationship education prior to government funding were typically acting proactively in order to prevent future problems. However, many of the couples who participated in more recent government-funded relationship education programs likely attended as a secondary prevention intervention. Couples may attend relationship education because they do not have alternative options for cost-effective relationship interventions that also provide supports, such as child care and other resources, to help make their attendance more feasible. The majority of relationship education attendees from recent studies were low-income, from diverse cultures, and not necessarily starting the program as relationally satisfied or stable. Couples may be experiencing relational conflict, symptoms of anxiety and depression, and parenting stress. Many couples may be co-parenting with a former partner, or are parenting a partner's child. Additionally, couples may not be relationally committed, or may be experiencing asymmetrical commitment (Stanley et al., 2019), in which one partner is more committed to the future of the relationship than the other.

Adaptations to Specific Populations

In order to reach wide applicability, relationship education curricula have been adapted and implemented with several specific subpopulations. Following, we describe considerations for some of these populations and include relevant research findings that have addressed relationship education effectiveness or implementation processes.

LOW-INCOME COUPLES

When working with low-income couples, understanding what stressors are influencing relational barriers is imperative (see also Chapter 12, "Socioculturally Attuned Coupled Therapy," in this volume, by Knudson-Martin & Kim). Stress related to economic and occupational instability has been shown to negatively influence couples' relationships and the overall well-being of families (Liu et al., 2020). Furthermore, low-income couples also experience barriers, such as a lack of transportation, insurance, and child care, that negatively impact relationship quality, as well as hinder engagement in couple therapy (Quirk, Strokoff, Owen, France, & Bergen, 2014). Due to the pressing nature of these barriers, low-income couples may not identify the health of their relationship as an immediate need in comparison to other life stressors; therefore, lower-frequency sessions may be suitable for couples who may not prioritize relationship issues (Hawkins, Carroll, Doherty, & Willoughby, 2004) due to these barriers. Furthermore, a flexible treatment modality, be it in a group or an in-home setting, to address relationship concerns offers opportunities to eliminate barriers that hinder low-income populations from obtaining services.

Other practical considerations to take into account when providing relationship education to individuals and couples with low income include the timing at which the education is being offered and the grouping of the program. Arnold and Beelmann (2019) suggest that providing relationship education early in the relationship and prior to transitioning into parenthood serves as a buffer to ruptures within the relationship for couples with low income.

LGBTQ COUPLES

Pepping, Halford, Cronin, and Lyons (2020) suggested that relationship education programs normed for heteronormative couples are just as effective for same-gender couples as they are for mixed-gender couples (Scott & Rhoades, 2014). One consideration, however, is that individuals who identify as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) may experience concerns that may not be present for cisgendered individuals, such as internalized homophobia, identifying ways to come out to family and friends, level of openness within the relationship (referring to fidelity status), and identifying identity-affirming steps (see also Chapter 23 on queer couples, in this volume, by Coolhart). Another consideration to acknowledge with the LGBTQ population is the out status of partners within LGBTQ relationships, and the nature of support received for the relationship from external sources such as family and friends. Relationship education curricula can be adjusted accordingly to incorporate and effectively address these concerns. Content geared toward family formation, such as discussing resources that may help LGBTQ couples achieve this, also should be considered and incorporated in the relationship curriculum. Efforts to incorporate strategies and support to address areas of concern such as these are important when providing relationship education to LGBTQ populations.

Furthermore, the way in which content is tailored should be considered, as most relationship education programs are specifically geared toward mixed-gendered couples. Content material during the intervention, and for marketing and recruitment purposes, should reflect images of same-gendered couples, as well as other members of the LGBTQ population. Due to the similarities in effectiveness of relationship education between mixed-gender and same-gender couples, 9 to 20 hours of relationship education may also be the optimal dose (Halford & Bodenmann, 2013). Facilitators who are familiar with the characteristics and concerns of LGBTQ populations are likely important to achieving positive outcomes as well.

MILITARY COUPLES

Hawkins and colleagues (2004) stated that relationship education within the military is ideal because military-related occupations make up a large portion of the U.S. workforce. Military couples exude a level of resilience that may manifest differently than with nonmilitary couples; however, they face obstacles that civilians may not encounter. Although military couples have greater access to resources such as health care and housing, they can experience instability in other ways due to frequent relocations, deployments to combat zones, and increased mental and physical health issues related to a military member's service. These factors impact military couples' willingness to establish support systems with other community members, impact the career advancement of the non-active-duty spouse or partner, and contribute to the inconsistent emotional connection between partners (Bakhurst, Loew, McGuire, Halford, & Markman, 2017). Therefore, when providing relationship education to military couples, programming should be relevant to the unique issues faced by these couples, such as deployment and staying emotionally engaged.

When considering the logistical aspects of relationship education for military couples, brevity, flexibility, and how programming is offered are particularly important because active military families can be called to deployment or relocation at a moment's notice. Implementing booster sessions to reinforce the curriculum, or providing opportunities to maintain a connection to other couples and the program, as well as opportunities to engage the nondeployed partner are important. Finally, the facilitators should be knowledgeable about the military culture, or be former military service personnel themselves.

Culture, Race, and Ethnicity

AFRICAN AMERICAN COUPLES

Discrimination and racism have a negative impact on relationship functioning (see Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). When providing relationship education to African American couples, it is important to understand how slavery, systemic racism, and the socialization of African American men and women as a result of these systems, influence relational dynamics (e.g., communication) in African American couples (Owen et al., 2012). Along with incorporating the impact of these systems within the relationship education curriculum, it is also important to incorporate aspects of history that reflect the strength of African American couples beyond slavery and also strengthen the ethnic identity of the couples. African American families tend to be more inclusive of extended family for support, which can influence how couples feel supported (Owen et al., 2012). This support can be a resource and source of strength for African American couples when integrated into relationship education programs.

An additional factor to consider when providing relationship education to African American couples is identifying where the relationship education will be provided. In a study that examined the efficacy of the Protecting Strong African American Families (ProSAAF) program on couples' relationship communication, satisfaction, and relationship confidence, 81% of participants engaged in all six sessions when the sessions were held within the participants' homes (Barton et al., 2017). Barton and colleagues suggested that using programs that are developed with a culturally sensitive framework, and training couples on the interventions using culturally specific and relevant experiences, improve African American couples' implementation of the interventions. Utilizing a culturally sensitive curriculum also includes using language associated with the population, which may include highlighting dialects such as African American Vernacular English or African American English (Mikle & Gilbert, 2019). Providing culturally sensitive relationship education increases awareness of identity and understanding of the negative impact of historical sociocultural factors among African American couples. Furthermore, similar to the other populations we have discussed, facilitators should represent the population and demonstrate cultural competence for issues relevant to African American couples.

LATINA/O COUPLES

Due to the heterogeneity and diversity among Hispanic populations, factors such as country of origin, documentation status, language fluency and barriers, trust, and reasons for migration are influential when providing relationship education to this population (Gutierrez, Barden, & Tobey, 2014). Particularly, in providing relationship education to Hispanic couples, facilitators should be aware of the differing values, traditions, and communities among Hispanic populations. For example, when creating or modifying curriculum, there are nuances in Spanish dialects that should be considered, as the language and meaning of words may vary based on region.

Furthermore, as Hispanic individuals migrate to new environments, they may experience increased stress associated with being in a new culture that serves as a barrier to utilizing mental health services (Gutierrez et al., 2014) and can impact relationship health. Additionally, there are unique needs, such as legal and emotional needs, that may be more urgent to address than relationship issues. Similar to other specific populations, knowing culturally relevant concepts and terminology helps to establish trust and rapport. For example, concepts such as *familismo* (family support) and *machismo y marianismo* are important values for Hispanic populations, and should therefore be incorporated in relationship education curriculum when relevant (Gutierrez et al., 2014).

AMERICAN INDIAN/ALASKA NATIVE COUPLES

American Indian/Alaska Native populations are distinctly unique minority populations due to their legal and political history. As the Indian Health Services department has previously been underfunded to address the mental health needs of American Indian/Alaska Natives, the Native American Healthy Marriage Initiative, established by the Administration of Children and Families, has since been developed to provide interventions and resources to strengthen Native American couples and families (Limb, White, & Holgate, 2014). Limb and colleagues recommended that clinicians providing relationship education to American Indian/Alaska Native couples should consider how to incorporate the cultural components of this population into the education provided. The collectivistic expectations that are strongly held within the American Indian/Alaska Native community and the inclusion of extended family to maintain important roles in the system, regardless of the parental relationship status, serve as protective factors for American Indian/Alaska Native couples.

American Indian/Alaska Natives are a vastly diverse population representing over 500 federally recognized nations. This means that individuals from different nations demonstrate different cultural and spiritual beliefs, as well as general differences that should be taken into account when providing relationship education (Lettenberger-Klein, Fish, & Hecker, 2013). Therefore, facilitators are encouraged to increase their knowledge of the specific tribes with which they are working and include community healers, tribal leaders, and others as educators or consultants in relationship education programming.

Empirical Support

Until more recent funding from the U.S. government, most relationship education research focused on White couples and was tested as a primary intervention addressing common couple issues before marriage (e.g., Halford, Markman, Kline, & Stanley, 2003); that is, couples participated in relationship education after they already had made a decision for a lifelong marital commitment. More recent relationship education research has focused on (1) diverse, low-income, and, in many cases, less stable couples that may not be as relationally committed as couples that begin premarital education or (2) married couples with limited resources for traditional couple therapy. In some instances, many of these couples were already experiencing significant stressors, and the government-supported relationship education programs offered the only entry point to relationship assistance. This, combined with the expansion to individual-oriented relationship education, provides an important context when considering findings from the studies we describe below. The majority of these studies were designed to target couples that experienced significant contextual stressors (e.g., unreliable transportation, shift-style work, or lack of resources), and these same contextual stressors present unique challenges to serving and studying them, some of which we discussed earlier in this chapter.

While numerous studies have been conducted on relationship education over the past three decades, we focus on some of the well-known and more rigorous studies. The first group includes the Building Strong Families (BSF; Wood, McConnell, Moore, Clarkwest, & Hsueh, 2010) and Supporting Healthy Marriages (SHM; Hsueh et al., 2012) studies. Across eight sites, BSF programs randomly assigned 5,102 unwed couples with young children, and SHM programs randomly assigned 6,298 married couples across nine sites. Both studies included relationship education intervention programs with 30 hours of relationship education using various curricula, case management services, and booster sessions. BSF targeted nonmarried couples who were expecting or recently had a baby. SHM targeted married couples with children under the age of 18. The BSF program did not result in more couples who stayed together or reported improvements in relationship quality at the 36-month follow-up across sites. However, one site in Oklahoma City demonstrated positive treatment gains for couples on relationship quality, conflict management, co-parenting, and father involvement. Couples who participated in Oklahoma were retained at higher rates and received a higher dose of the treatment intervention than other programs. Thus, attrition was a significant challenge in the BSF study. The SHM program resulted in small, positive effects for couples at 30-month follow-up on relationship quality, co-parenting, parenting, and child well-being, as well as women's feelings of sadness and anxiety. However, SHM treatment group couples were no more likely to stay together than control group couples at the end of the study.

The Parents and Children Together (PACT; Moore, Avellar, Patnaik, Covington, & Wu, 2019) study was another multisite, randomized trial that targeted couples with children and included economic stability services. Two program sites in Texas and New York randomly assigned 1,595 couples to a treatment or no-services control group. Findings at 12-month follow-up included positive effects on couple commitment, quality of co-parenting relationships, reduction in women's depressive sypmtoms, and an increased likelihood that couples were married after 12 months.

The results from these three large-scale studies are mixed. However, several meta-analytic studies have been conducted on the effectiveness of relationship education (e.g., Arnold & Beelmann, 2019; Hawkins & Erickson, 2015) and have shown that couples who attended relationship education generally experienced small, statistically significant improvements in communication, conflict, and relationship satisfaction. The meta-analytic studies included randomized controlled trials, as well as pre–post quasi-experimental designs. However, there are nuanced differences among study results for relationship education when these study designs, constructs, and subpopulations are considered separately. For example, subgroups analyses showed that when couples begin relationship education with more distress, they tend to demonstrate greater magnitude of change from pre- to postassessment than their nondistressed counterparts (Carlson et al., 2017), but distressed couples are more difficult to retain. Additionally, relationship education participants reported improvements on individual outcomes, such as feelings of anxiety and depression (Roddy, Rhoades, & Doss, 2020), and there is some evidence that relationship education reduces intimate partner violence, even if only one partner attends (Carlson, Wheeler, & Adams, 2018).

Limitations and Future Directions

There are important limitations to the relationship education research to note. First, many of the studies showing more positive impacts do not include long-term follow-ups. Therefore, it is not clear if the positive effects endure beyond a few months or 1 year. Second, it is not yet clear what mechanisms contribute to positive change for couples. The few studies that compared curricula (e.g., Doss et al., 2020), found nominal differences that did not result in statistical significance. Some studies showed that communication skills building resulted in improved outcomes (Barton et al., 2017), whereas others did not (Rogge, Cobb, Lawrence, Johnson, & Bradbury, 2013), although communication skills are still regarded as a primary change mechanism or reason for positive gains after attending relationship education. Third, there may be benefits to relationship education beyond relationship quality outcomes that are relatively understudied. For example, Hawkins, Allen, and Yang (2017) found relationship education improved relationship hope for couples. Roddy and colleagues (2020) found sustained impacts for individual mental and physical health for those taking OurRelationship or ePREP. Additionally, there is growing support for the idea that social support and improved social networks mediate outcomes (Carlson, Wheeler, Liu, Hipp, & Daire, 2020). The alliances among workshop participants are important (Owen, Antle, & Barbee, 2013), and relationship education facilitators who demonstrate warmth and clarity with curriculum delivery have been shown to contribute to more positive outcomes (Higginbotham & Myler, 2011).

There are more nuanced implementation considerations, such as curriculum length, format, and modality, that remain understudied. One meta-analysis identified medium-length curricula (9–20 hours) as most effective (Hawkins, Stanley, Blanchard, & Albright, 2012). However, more research is needed to understand whether universally implemented relationship education is the most effective approach for couples, or whether relationship education tailored to address specific concerns and presenting issues would generate more positive effects. Relationship education modalities (e.g., online vs. face-to-face) have not been widely studied either. Furthermore, relationship education provided by clergy or secular facilitators has been shown to be equally effective (Hawkins et al., 2012), and weekend workshops versus multiple-week modalities have also been shown to be equally effective (Carlson, Daire, & Bai, 2014). Finally, to our knowledge, no studies have examined the use of relationship education in a traditional therapy setting, although one article offers insights and guidance regarding the integration of relationship education skills in therapy (Markman & Rhoades, 2012).

CONCLUDING COMMENTS

Given the long history of relationship education as a primary prevention for later relationship problems, extensive research supporting its effectiveness as a primary and secondary intervention, and flexible delivery options with numerous curricula and modalities, therapists who work with couples should strongly consider the use of this intervention. Three potential methods for implementing relationship education include offering it as a stand-alone intervention, as a supplement to couple therapy, or integrating the skills into couple therapy sessions. Among these methods, delivery options include face-to-face or online (asynchronous or synchronous). Relationship education is an applicable treatment option for diverse couples and can be adapted in content and delivery to address the specific context of the intended target population. Finally, the existing and emerging body of research supports relationship education as an efficacious intervention for a broad population of couples, including couples who experience structural barriers to traditional couple therapy. With numerous rigorous studies still underway, more evidence is forthcoming that may resolve ongoing implementation challenges such as what works best and for whom. However, relationship education has shown promise as an effective intervention for couples already experiencing relationship distress, indicating that distress prevention approaches may also ameliorate some preexisting levels of current relationship distress, especially for vulnerable couples.

SUGGESTIONS FOR FURTHER STUDY

Bradford, A. B., Hawkins, A. J., & Acker, J. (2015). If we build it, they will come: Exploring policy and practice implications of public support for couple and relationship education for lower income and relationally distress couples. *Family Process, 54,* 639–654.

Markman, H. J., & Rhoades, G. K. (2012). Relationship education research: Current status and future directions. *Journal of Marital and Family Therapy, 38,* 169–200.

Markman, H. J., & Ritchie, L. L. (2015). Couples relationship education and couples therapy: Healthy marriage or strange bedfellows? *Family Process, 54,* 655–671.

Stanley, S. M., Carlson, R. G., Rhoades, G. K., Markman, H. J., Ritchie, L. L., & Hawkins, A. J. (2020). Best practices in relationship education focused on intimate relationships. *Family Relations, 69,* 497–519.

REFERENCES

Arnold, L. S., & Beelmann, A. (2019). The effects of relationship education in low-income couples:

A meta-analysis of randomized-controlled evaluation studies. *Family Relations, 68,* 22–38.

Bakhurst, M. G., Loew, B., McGuire, A. C., Halford, W. K., & Markman, H. J. (2017). Relationship education for military couples: Recommendations for best practice. *Family Process, 56,* 302–316.

Barton, A. W., Beach, S. R. H., Lavner, J. A., Bryant, C. M., Kogan, S. M., & Brody, G. H. (2017). Is communication a mechanism of relationship education effects among rural African Americans. *Journal of Marriage and Family, 79,* 1450–1461.

Braithwaite, S. R., & Fincham, F. D. (2009). A randomized clinical trial of a computer based preventive intervention: Replication and extension of ePREP. *Journal of Family Psychology, 23,* 32–38.

Carlson, R. G., Daire, A. P., & Bai, H. (2014). Examining relationship satisfaction and individual distress for low-to-moderate income couples in relationship education. *Family Journal, 22,* 282–291.

Carlson, R. G., Dillman Taylor, D., Barden, S. M., Olejarczyk, J., & Glascoe, G. (2021). Effects of individual-oriented relationship education on parents: A randomized controlled trial. *Journal of Family Psychology, 35,* 1097–1106.

Carlson, R. G., Rappleyea, D. L., Daire, A. P., Harris, S. M., & Liu, X. (2017). The effectiveness of couple and individual relationship education: Distress as a moderator. *Family Process, 56,* 91–104.

Carlson, R. G., Wheeler, N. J., & Adams, J. (2018). The influence of individual-oriented relationship education on equality and conflict-related behaviors. *Journal of Counseling and Development, 96,* 144–154.

Carlson, R. G., Wheeler, N. J., Barden, S. M., Romagnolo, S., Dillman Taylor, D., Hipp, C. J., . . . Moran, M. (2021). Using intent to attend as a predictor of retention in community-based relationship education. *Family Process.* [Epub ahead of print]

Carlson, R. G., Wheeler, N. J., Liu, X., Hipp, C., & Daire, A. P. (2020). The relationship between social support and family relationships among low-income couples attending relationship education. *Family Process, 59,* 1498–1516.

Doss, B. D., Knopp, K., Roddy, M. K., Rothman, K., Hatch, S. G., & Rhoades, G. K. (2020). Online programs improve relationship functioning for distressed low-income couples: Results from a nationwide randomized controlled tiral. *Journal of Consulting and Clinical Psychology, 88,* 283–294.

Gutierrez, D., Barden, S. M., & Tobey, M. H. (2014). Mejorando matrimonios: Relationship education as a vehicle to overcome barriers for Hispanic couples. *Family Journal, 22,* 148–155.

Halford, W. K., & Bodenmann, G. (2013). Effects of relationship education on maintenance of couple relationship satisfaction. *Clinicial Psychology Review, 33,* 512–525.

Halford, W. K., Markman, H. J., Kline, G. H., & Stanley, S. (2003). Best practice in couple relationship education. *Journal of Marital and Family Therapy, 29,* 385–406.

Halford, W. K., Markman, H. J., & Stanley, S. (2008). Strengthening couples' relationships with education: Social policy and public health perspectives. *Journal of Family Psychology, 22,* 497–505.

Halford, W. K., Petch, J., Creedy, D. K., & Gamble, J. (2011). Intimate partner violence in couples seeking relationship education for the transition to parenthood. *Journal of Couple and Relationship Therapy, 10,* 152–168.

Hawkins, A. J., Allen, S. E., & Yang, C. (2017). How does couple and relationship education affect relationship hope?: An intervention-process study with lower income couples. *Family Relations, 66,* 441–452.

Hawkins, A. J., Carroll, J. S., Doherty, W. J., & Willoughby, B. (2004). A comprehensive framework for marriage education. *Family Relations, 53,* 547–558.

Hawkins, A. J., & Erickson, S. E. (2015). Is couple and relationship education effective for lower income participants?: A meta-analytic study. *Journal of Family Psychology, 29,* 59–68.

Hawkins, A. J., Stanley, S. M., Blanchard, V. L., & Albright, M. (2012). Exploring programmatic moderators of the effectiveness of marriage and relationship education programs: A meta-analytic study. *Behavior Therapy, 43,* 77–87.

Higginbotham, B. J., & Myler, C. (2011). The influence of facilitator and facilitation characteristics on participants' ratings of stepfamily education. *Family Relations, 59,* 74–86.

Hsueh, J., Alderson, D. P., Lundquist, E., Michalopoulos, C., Gubits, D., & Fein, D. (2012). *The Supporting Healthy Marriage Evaluation: Early impacts on low-income families, technical supplement* (OPRE Report 2012-27). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Jakubowski, S. F., Milne, E. P., Brunner, H., & Miller, R. B. (2004). A review of empirically supported marital enrichment programs. *Family Relations, 53,* 528–536.

Johnson, S. M. (2008). *Hold me tight: Conversations for a lifetime of love.* New York: Little, Brown.

Lettenberger-Klein, C. G., Fish, J. N., & Hecker, L. L. (2013). Cultural competence when working with American Indian populations: A couple and family therapist perspective. *American Journal of Family Therapy, 41,* 148–159.

Limb, G. E., White, C., & Holgate, M. (2014). Strengthening American Indian couples' relationship quality to improve parenting. *Journal of Human Behavior in the Social Environment, 24,* 92–104.

Liu, X., Wheeler, N. J., Broda, M. D., Daire, A. P., Dominquez, V. N., Griffith, S. M., & Pease,

J. C. (2020). Relationship satisfaction trajectories among low-income ethnic minority couples before and after relationship education intervention. *Journal of Social and Personal Relationships, 37,* 2053–2077.

Markman, H. J., & Floyd, F. J. (1980). Possibilities for the prevention of marital discord: A behavioral perspective. *American Journal of Family Therapy, 8*(2), 29–48.

Markman, H. J., & Rhoades, G. K. (2012). Relationship education research: Current status and future directions. *Journal of Marital and Family Therapy, 38,* 169–200.

Markman, H. J., & Ritchie, L. L. (2015). Couples relationship education and couples therapy: Healthy marriage or strange bedfellows? *Family Process, 54,* 655–671.

Markman, H. J., Stanley, S. M., & Blumberg, S. L. (2010). *Fighting for your marriage.* San Francisco: Jossey-Bass.

Mikle, K. S., & Gilbert, D. J. (2019). A systematic review of culturally relevant marriage and couple relationship education programs for African-American couples. *Journal of Ethnic and Cultural Diversity in Social Work, 28,* 50–75.

Moore, Q., Avellar, S., Patnaik, A., Covington, R., & Wu, A. (2019). *Effects of two healthy marriage programs for low-income couples: Evidence from the Parents and Children Together Evaluation* (OPRE Report 2019–06). Washington, DC: Administration for Children and Families, Office of Planning, Research, and Evaluation.

Owen, J., Antle, B., & Barbee, A. (2013). Alliance and group cohesion in relationship education. *Family Process, 52,* 465–476.

Owen, J., Chapman, L. K., Quirk, K., Inch, L. J., France, T., & Bergen, C. (2012). Processes of change in relationship education for lower-income African American couples. *Journal of Couple and Relationship Therapy, 11,* 51–68.

Parrott, L., Parrott, L., & Olson, D. H. (2021). *Helping couples: Proven strategies for coaches, counselors, and clergy.* Grand Rapids, MI: Zondervan.

Pearson, M., Stanley, S. M., Rhoades, G. K. (2008). *Within My Reach instructor manual.* Greenwood Village, CO: PREP for Individuals.

Pepping, C. A., Halford, W. K., Cronin, T. J., & Lyons, A. (2020). Couple relationship education for same-sex couples: a preliminary evaluation of rainbow CoupleCARE. *Journal of Couple and Relationship Therapy, 19,* 230–249.

Quirk, K., Strokoff, J., Owen, J. J., France, T., & Bergen, C. (2014). Relationship education in community settings: Effectiveness with distressed and non-distressed low income racial minority couples. *Journal of Marital and Family Therapy, 40,* 442–453.

Rhoades, G. K., & Stanley, S. M. (2011). Using individual-oriented relationship education prevent family violence. *Journal of Couple and Relationship Therapy, 10,* 185–200.

Roddy, M. K., Georgia, E. J., & Doss, B. D. (2017). Couples with intimate partner violence seeking relationship help: Associations and iplications for self-help and online interventions. *Family Process, 57,* 293–307.

Roddy, M. K., Rhoades, G. K., & Doss, B. D. (2020). Effects of ePREP and OurRelationship on low-income couples mental health and health behaviors: A randomized controlled tiral. *Prevention Science, 21,* 861–871.

Rogge, R. D., Cobb, R. J., Lawrence, E., Johnson, M. D., & Bradbury, T. N. (2013). Is skills training necessary for the primary prevention of marital distress and dissolution?: A 3-year experiemental study of three interventions. *Journal of Consulting and Clinical Psychology, 81,* 949–961.

Scott, M. E., & Huz, I. (2020). *An overview of healthy marriage and relationship education curricula* (Research Brief). Bethesda, MD: Marriage and Strengthening Ressearch and Dissemination Center.

Scott, S. B., & Rhoades, G. K. (2014). Relationship education for lesbian couples: Perceived barriers and content considerations. *Journal of Couple and Relationship Thereapy, 13,* 339–364.

Stanley, S. M., Amato, P. R., Johnson, C. A., & Markman, H. J. (2006). Premarital education, marital quality, and marital stability: Findings from a large, random household survey. *Journal of Family Psychology, 20,* 117–126.

Stanley, S. M., Carlson, R. G., Rhoades, G. K., Markman, H. J., Ritchie, L. L., & Hawkins, A. J. (2020). Best practices in relationship education focused on intimate relationships. *Family Relations, 69,* 497–519.

Stanley, S. M., Rhoades, G. K., Kelmer, G., Scott, S. B., Markman, H. J., & Fincham, F. D. (2019). Unequally into "Us": Characteristics of individuals in asymmetrically committed relationships. *Family Process, 58,* 214–231.

Van Epp, J. (2007). *How to avoid falling in love with a jerk: The foolproof way to follow your heart without losing your mind.* New York: McGraw-Hill.

White, T. J. E., Duncan, S. F., Yorgason, J. B., James, S. L., & Holmes, E. K. (2020). Marital interventions: Participation, helpfulness, and change in a nationally representative sample. *Family Relations, 69,* 125–137.

Williamson, H. C., Trail, T. E., Bradbury, T. N., & Karney, B. R. (2014). Does premarital education decrease or increase couples' later help-seeking? *Journal of Family Psychology, 28,* 112–117.

Wood, R. G., McConnell, S., Moore, Q., Clarkwest, A., & Hsueh, J. (2010). *The Building Strong Families Project: Strengthening unmarried parents' relationships: The early impacts of building strong families.* Princeton, NJ: Mathematica Policy Research.

CHAPTER 30

Telehealth and Digital Couple Interventions

Brian D. Doss, Kayla C. Knopp, Elizabeth R. Wrape, and Leslie A. Morland

In less than 15 years, we have gone from the introduction of the iPhone to the COVID-19 pandemic—from viewing the use of technology in treatment as a possibility to viewing it as a necessity. In the future, we believe technology will play an increasingly central role in couple therapy for several reasons. Couples see online treatment as a viable option for improving their relationships. As of this writing, some of the most popular providers of online couple therapy (e.g., Regain.us; TalkSpace.com) each receive over 1 million visits per month. Furthermore, research indicates that couples seek online relationship interventions and in-person couple therapy for similar relationship problems, such as communication difficulties, lack of emotional intimacy, and loss of trust (Roddy, Rothman, Cicila, & Doss, 2019).

One of the reasons for the popularity of online relationship interventions is that they fill gaps that are often unmet by in-person couple therapy. One important need is for an effective intervention earlier in the help-seeking process. Couples wait approximately 2–7 years after realizing they have a serious relationship problem before seeking couple therapy (Doherty, Harris, Hall, & Hubbard, 2021; Jarnecke et al., 2020). During this delay, couples seek alternative forms of help for their relationships, including informal help from friends, family, books, magazines, and websites (Doss, Rhoades, Stanley, & Markman, 2009; Georgia & Doss, 2013; Jarnecke et al., 2020). Additionally, most couples never seek traditional couple therapy before getting a divorce or breaking up (Johnson et al., 2002). This underutilization can be partially explained by the logistical (e.g., scheduling, child care, transportation) and financial (e.g., lack of insurance coverage) barriers to couple therapy. There are important psychological barriers as well: the stigma about therapy in general, the reluctance of one or both partners to talk about private relationship issue with a therapist, and the difficulty of introducing the idea of attending couple therapy to the partner. As we describe later in this chapter, technology can address many of the limitations of traditional couple therapy and may have the potential to make in-person couple therapy briefer and/or more effective.

DISTINGUISHING TELEMENTAL HEALTH AND DIGITAL COUPLE INTERVENTIONS

The use of technology in couple therapy has important benefits for couples, therapists, and third-party payers. However, before proceeding further, it is important to make a distinction between two broad ways in which technology can be used in couple therapy—telemental health and digital couple interventions.

Telehealth for mental health treatment, also referred to as telemental health or TMH, refers to the provision of psychotherapy or other mental health services using a synchronous technology, usually videoconferencing. TMH allows patient and provider to meet in real time, irrespective of location over a video platform. In other words, TMH is therapy as it is practiced in any other setting, except it is done using Internet-based video communication rather than together in person. TMH reduces barriers to couple treatment due to reduced need for transportation, more flexible afterhours availability, and increased access to specialty care providers.

Digital couple interventions (DCIs) are computer-based, online, or mobile app programs that are used to present information relevant to couple treatment, typically in an interactive way. DCIs are primarily asynchronous, which means couples can access them whenever they choose, without needing to schedule an appointment with a provider (although some DCIs do include some amount of synchronous provider contact, as described below). The other factor that distinguishes DCIs from TMH is that the intervention content is provided by the program, for example, through videos or text rather than by a therapist. Because of this, DCIs are typically not considered *therapy*, although they may be considered *interventions* for treating relationship distress. There are several ways for couple therapists to integrate DCIs into their practice, as we describe below.

In this chapter, we first cover the role of TMH in couple therapy, emphasizing clinical factors such as logistical, ethical, and legal considerations. We then transition to a discussion of DCIs, covering how they can be utilized prior to couple therapy, as an adjunct to couple therapy, or integrated into the core of a course of couple therapy. We also review the research supporting the use of TMH as well as DCIs. Throughout the chapter, we have attempted to focus our examples on technology and programs that are well established and have sufficient traction (e.g., integration with state or federal services; consistent grant funding) that they can be expected to be available for at least several years after publication.

TMH FOR COUPLES

The pervasiveness of connected technology over the past decade has enabled changes in the ways that people all over the world accomplish tasks of daily living, ranging from banking and shopping to maintaining intimate relationships. It is not surprising that this technological infrastructure has inspired clinicians and providers to leverage this same technology to address the myriad barriers to accessing mental health care. TMH, which allows a mental health provider and patient in separate locations to see each other and interact in real time ("synchronously"), is perhaps the most widely used and studied telehealth modality of care relative to telehealth for physical concerns. Decades of rigorous research consistently support that mental health services, including psychotherapy and psychiatry, delivered over a TMH modality are as clinically effective as traditional in-person care for treating a range of mental health conditions (Berryhill et al., 2018; Varker, Brand, Ward, Terhaag, & Phelps, 2019). In the United States, there is a trend among most major insurance companies to reimburse for telehealth care at the same rate as in-person care, although policies and their implementation still vary widely. As with any change in policy or practice, many clinicians experience challenges in aligning billing and regulatory requirements (e.g., adding a telehealth modifier to the billing code for insurance claims) with their clinical practices. Still, both patients and health care systems are increasingly aware of the need for more access to high-quality mental health care and increasingly acknowledge the ability of TMH to meet that need.

TMH is a particularly useful modality for couples, as it removes or reduces many of the barriers to in-person treatment. By eliminating the need to travel to an in-person appointment, which can add up to several hours of travel time to a 1-hour psychotherapy session, couples have much more flexibility in coordinating both partners' schedules and can save money on travel costs. Removing travel requirements can also make couple therapy more accessible to lower-income or other couples that do not have reliable transportation, which improves equity of access to care. By attending therapy sessions from their home, couples may also reduce the need to obtain child care, which is another expense associated with in-person couple therapy (although providers often need to strategize with couples about appropriate ways to manage children in the home during couple therapy sessions, as described in more detail below). Finally, couples seeking TMH therapy can expand the pool of available providers, typically to the entire state or licensing jurisdiction rather than just their local therapist market. Given the dearth of well-trained couple therapists, being able to access providers that are geographically distant can improve the quality of treatment couples receive.

Research on TMH for Couples

Despite the robust research on TMH for individual mental health treatment, there are few empirical examinations of couple therapy utilizing telehealth services. At the same time, TMH for couple therapy is increasingly becoming widely used, and some studies of couple therapy now include TMH as a de facto equivalent to in-person treatment, particularly in health care systems with well-integrated telehealth infrastructures such as the Veterans Administration (VA; e.g., Fischer, Bhatia, Baddeley, Al-Jabari, & Libet, 2018). One recently completed study comparing the clinical efficacy of a brief cognitive-behavioral conjoint therapy for posttraumatic stress disorder (PTSD) delivered via an office-based or a home-based TMH delivery modality compared to an active control condition found that both office-based and TMH conditions reduced PTSD symptoms and improved couples' satisfaction over the course of treatment, with no significant differences in treatment retention or efficacy between the office-based and TMH conditions (Morland, Knopp, et al., 2020).

Furthermore, during the COVID-19 pandemic, nearly all couple therapy (as well as most mental health treatment) quickly pivoted to a TMH modality because in-person access to treatment was severely restricted. The pandemic highlighted both the value of TMH for couple therapy and the need for further empirical research with couples. Prior to the onset of the pandemic, technology-based offerings could lack proper consideration of factors such as crisis resources and legal ramifications of cross-state practice—domains that are in sharper focus now (Gassova & Werner-Wilson, 2018). In the time since, virtual care practices have offered many lessons learned regarding clinical, logistical, and regulatory considerations that are imperative to consider when using TMH for couple therapy.

Clinical Considerations When Implementing TMH for Couples

Wrape and McGinn (2019) explored many of the following recommendations when considering couple therapy via a telehealth modality. For additional practical advice on providing relational teletherapy, see Burgoyne and Cohn (2020), and for resources on ethical concerns, see the American Association for Marriage and Family Therapy's Code of Ethics (2015), included in the list of "Suggestions for Further Study" at the end of this chapter.

Informed Consent and Privacy

As clinicians explore the clinical considerations of offering TMH services, utilizing in-person procedures for couple therapy can be a beneficial place to begin. For instance, providers should still complete typical consent procedures including limits of confidentiality and expectations for treatment (see Chapter 31 on ethics, in this volume, by Margolin, Gordis, & Rasmussen), with adaptations for TMH. These modifications depend on the regulations of the licensing jurisdiction but commonly include specific consent to receive services via TMH, clarifying the allowable locations of the patient and provider (e.g., limitations on crossing state or international boundaries), specifying technological requirements (e.g., high-speed Internet), creating contingency plans for technical problems, and information about Internet data security measures. Further description and guidelines on implementation of these adaptions, including sample language, can be accessed through an American Psychological Association checklist, available at *www.apa.org/practice/programs/dmhi/research-information/informed-consent-checklist*.

There are a number of additional considerations of which clinicians should be mindful and work to communicate clearly to couples. When starting any TMH care, there should be a more explicit discussion about creating a virtual therapeutic environment in order to set the therapy process up for success and safety. To this end, more emphasis and clarification should be placed on the discussion of privacy. Clinicians may wish to inform the couple of their role in maintaining their privacy within their respective remote setting (e.g., home, car). This extends to the privacy afforded by a secured, private WiFi connection versus a public Internet connection, such as one at a library or coffee shop. Privacy is the couple's right and responsibility, and a clinician in-office can have greater control over this variable than a clinician providing care to a couple remotely. Following the conversation with the couple about the importance of privacy in session, clinicians should contemplate addressing potential privacy violations should they occur in future sessions. For example, if the clinician views an unexpected presence on the screen or suspects, based on body language, that there may be someone else in the room, they may pause the session and check in with the couple about continuing due to privacy concerns. Communicating this expectation clearly at the outset of treatment may prevent confusion later, when the situation occurs and can assist in preventing a rupture or setting a future boundary.

Additionally, when discussing limits of confidentiality, clinicians should make couples aware of the relevant crisis and emergency services for mandated reporting of safety concerns. Laws regarding reporting of child abuse and domestic violence are particularly relevant for couple therapy. As states have distinct regulations, communication should be clear as to which sets of rules are at play. Further suggestions regarding emergencies are covered below; however, the main recommendation is that should an emergency occur in session, couples should be aware in advance of how it will be handled, including whether emergency services will be called and under what circumstances that could occur.

Finally, clinicians should communicate with couples about expectations for decorum during therapy. This is good practice for in-person treatment; however, when couples are in their home, it can be easier for boundaries to slip regarding what is and is not appropriate for a therapy context. It can be helpful to provide a reminder that couples should behave over TMH in the same way that they would behave if they were attending treatment in the therapist's office. Couples should ideally select a location in their home that affords both privacy and professionalism, such as a home office, and should avoid overly casual or intimate settings such as bathrooms or beds, if at all possible, as well as prohibitions against attending sessions from a moving car. Lighting and volume problems should be addressed prior to beginning the session so as not miss important visual and auditory data crucial to conducting some forms of couple therapy. Attention to these aspects should be consistent with the level of care being provided (e.g., phone coaching vs. emotion-focused therapy).

Similarly, couples should dress in clothing appropriate for outside the home. Couples should also be mindful that clinicians cannot "unsee" something that may be on camera, including objects (e.g., weapons, illegal pornography) or behaviors (e.g., physical discipline of a child) that may be subject to mandated reporting. Other types of visuals may simply be uncomfortable for both clinicians and clients. Clinicians may want to recommend that couples remove or tidy clutter in the room used for sessions, both to reduce distractions and to avoid these types of problems. Similarly, as much as possible, couples should expect to devote all their attention to the therapy session while it is occurring. It may be helpful to troubleshoot potential distractions that may occur while the couple is in their home environment (TVs on in the background, children or other family members needing attention, other household members creating noise, receiving text messages, doing chores, etc.—the list is long) and help the couple plan to avoid those during session. Finally, therapists should be mindful of their own virtual environment when providing telehealth services given that many therapists may be working from a home in which the presence of children, a partner, or pets can be equally distracting to the therapy process. Creating a virtual environment that is predictable, professional, and free from distraction is critical to the successful provision of teletherapy.

Contraindications for Couple Therapy and TMH

Consistent with in-person couple therapy, there are important clinical considerations to assess when determining whether TMH is an appropriate modality for a given couple. Such considerations include assessing for individual safety, intimate partner violence (IPV), and the appropriateness of the intervention to be used. A clinician conducting couple therapy should be broadly aware of typical contraindications (e.g., moderate to severe IPV, fear or intimidation, severe symptoms that may prohibit meaningful engagement in the process such as active psychosis). These contraindications are mirrored in TMH. One broad recommendation is the importance of proactive versus reactive crisis planning. This applies to in-office conditions and TMH; however, this recommendation becomes even more important given the reduction in clinician control inherent in the telehealth modality. Consistent with preparing to manage risk remotely using TMH for individuals, proactive steps include documenting the couple's location so as to know where to send in-person emergency services, awareness of immediate local emergency resources for the patient if the clinician is not local, and designation of an emergency contact should another person need to be involved. All of these aspects should be discussed with the couple so they are aware of what steps will occur in accordance with limits of confidentiality.

We have mentioned the benefit of TMH to couples that have difficulties accessing child care. While this is true, the presence of children in the home can still serve as a barrier. For conjoint and individual sessions, providers may want to create a policy regarding the presence of dependent others (e.g., children). These considerations should include infants, who often have more immediate needs than older children and can be distracting in session. Some providers may request that all children be outside of the session space, while others feel comfortable if the child (dependent on age) is in the room but distracted with audio/visual technology. All providers who are aware that children are part of the context of the situation should also prepare for sessions to be interrupted frequently or intermittently, and to be able to set boundaries with the couple regarding the appropriateness of the risks inherent in the child overhearing developmentally inappropriate content. These boundaries can vary in rigidity; however, the overall recommendation is for children to be shielded from damaging parental interactions, as exposure to parental conflict negatively impacts child well-being (Harold & Sellers, 2018). After explicitly discussing these boundaries, collaborative problem solving is good modeling for the type of work that couple therapy often entails. For instance, the couple may be able to meet with the provider in a non-moving car outside of an organization that provides child care for an hour, meet during the child's scheduled naptime (with safeguards present), or enlist a family member to care for the child while the couple removes themselves to another room. The important balance to strike is one of providing effective care while safeguarding the couple's privacy and their children's well-being.

Measurement-Based Care and Assessment

An additional logistical difference between in-person and TMH care is in implementing measurement-based care. Assessment packets are easily provided to couples and retrieved when meeting in-person, maintaining the confidentiality of each partner if they followed clinician requests (e.g., to complete the measures privately and separately). However, electronic transmission of assessment data should be attended to carefully in accordance with the Health Insurance Portability and Accountability Act (HIPAA; 1996) and with an eye toward confidentiality within the couple. For instance, if there are IPV concerns that could induce fear or intimidation in one member of the couple, self-report data and discussion of these aspects of the relationship should be safeguarded. Clinicians should look to state, organizational, and discipline-specific guidance regarding use of e-mail or other forms of electronic communication with couples, as different restrictions exist. Appropriate methods may include encrypted e-mail, HIPAA-compliant phone and text numbers, and secure messaging embedded with an electronic health record system for an organization or individual practitioner.

Self-report measures are only part of a multipronged assessment of important relational experiences. An approach that considers both written and verbal data collection from both members of the couple separately can ensure a more comprehensive picture. Although verbal assessment in TMH can mirror therapy procedures, there are concerns regarding collection of information from each partner independently about sensitive topics such as IPV or sexual difficulties. In general, the clinician can tailor how to gather this information based on clinical judgment; that is, if the clinician suspects that a higher degree of privacy is needed given the characteristics of the couple, information collection should be cautious in nature. If a higher level of confidentiality is warranted, clinicians could consider the following:

1. Use of headphones and conducting assessment by asking yes–no questions rather than eliciting open-ended responses.
2. Purposeful relocation, such as asking a person to log in from a car instead of a home where the partner is present.
3. Use of the chat function that is available in many telehealth platforms to have the partner type rather than speak aloud particularly sensitive information.

Taking steps such as these can allow clinicians to switch to safety planning more readily, with fewer concerns regarding the consequences of the other partner overhearing it. Clinicians should also be aware of how they are providing resources for safety planning, ensuring that electronic means are secure. Prompting the client for a trusted friend or family member to send safety resources and/or safety plan documents is an additional way to protect an individual if there are concerns about the couple sharing devices, e-mail accounts, and passwords, or about one partner monitoring or checking the other's phone (as is sometimes the case in cycles of abuse; Hertlein, Eddy, & Lancaster Strickland, 2020).

Clinical Interventions over TMH

BUILDING THE THERAPEUTIC RELATIONSHIP

As one might imagine, screens create additional variables in the domains of engagement and therapeutic alliance. Studies comparing therapeutic process variables such as session attendance (Morland, Mackintosh, et al., 2020), patient and clinician satisfaction (Gross, Lancaster, López, & Acierno, 2018), and therapeutic alliance in individual therapy have found TMH services to be comparable to in-person care. Despite some clinician apprehension, there is no research evidence to suggest the working alliance is necessarily reduced over TMH (Lopez, Schwenk, Schneck, Griffin, & Mishkind, 2019). Rather, adjustments can be made to ensure couples understand that a clinician is engaged and listening that differ from in-person situations. For instance, making "eye contact" over TMH usually involves looking at the location of the therapist's camera on their screen or webcam rather than looking directly at the image of the client on the screen; it is helpful to place the image of the couple near the location of the webcam (e.g., top center of the screen). Additionally, some therapists find it jarring to see a video of their own face during sessions (the default setting for many telehealth platforms), whereas other therapists may need initially to practice observing how their own facial expressions, gestures, and eye contact come across over a virtual modality. We encourage therapists to spend some time practicing their therapeutic techniques over TMH while observing themselves, and subsequently to experiment with hiding the self-view video in the settings of the telehealth platform to reduce being distracted by evaluating one's own appearance and gestures.

In-person couple therapy often includes small gestures to indicate which member of the couple the clinician is prompting to share, but these subtle gestures can get lost in virtual modalities—for example, if a clinician gestures to the partner to the right on their screen, this may or may not translate to the same partner based on the couple's perspective of the therapist's video. Using partners' names more often can function in a similar way, both as a signal to share and a tool of redirection. Therapists can still use body language, such as hand gestures and sitting forward toward their screen versus back in their chair, to direct aspects of the emotional tone of the session, although the range of behaviors observable over TMH is reduced. Similarly, some clinicians value the use of physical space in session. TMH clinicians may need to provide more explicit instructions to couples about how closely to sit, when to turn to one another to speak, and so forth. Finally, clinicians' use of slowed, softer speech to deepen affect may be less effective if couples are unable to discern what is being said due to volume on the device or microphone sensitivity. Still, other common techniques for intervening with couples—such as RISSC (Review sessions, Immerse in model, Slow down and attend to present, Stretch ourselves, and Commit to the model) skills in EFCT (see Chapter 6, "Emotionally Focused Couple Therapy," in this volume, by Johnson, Wiebe, & Allan)—are likely to translate effectively. Therefore, clinicians may need to broaden their toolbox of verbal and nonverbal strategies to select those most effective in a TMH context.

HOME-BASED PRACTICE

Skills practice in the home may be an area of added value in TMH. Practicing skills in session with a couple may better generalize when couples are present in the environment where these skills will be utilized in the future. For instance, if the couple is creating their time-out strategy, they may have visual cues available as to how they will regulate themselves or to what locations they will separate. If indicated, the couple can role-play these skills in session with the clinician. Similarly, teaching parents more effective ways to redirect their children can take place if a child disrupts the session, whereas in person, a child would likely be absent completely. Further research is needed to determine whether this hypothesis regarding context-dependent learning holds. Even without an impact on client learning per se, clinicians may have a useful window into clients' lives (e.g., the physical state of their home, how they interact with one another and other family members in their home environments) that can help inform case conceptualization and may even pose a useful target for treatment.

CONFLICT MANAGEMENT

It is the nature of couple therapy that relationship distress often leads to heightened affect. TMH clinicians may find that some couples can shut out or dismiss redirection given their absence from the room, so early discussion will plant seeds for later intervention. For conflict between the couple in session that does not fall under the need for emergency services, it would behoove the clinician to collaboratively and proactively discuss steps for deescalation and general appropriate behavior. Clinicians can set healthy communication guidelines such as reducing interruptions, damaging language, and negative tone, while also setting the frame for approximately equal participation as an introduction in the first session. Couples can be prepped for times when the clinician verbally or nonverbally (e.g., time-out signal) wishes to disrupt the ongoing process in session. Teaching strategies to the couple ahead of time, such as deep breathing or temporarily stepping out of the room, can allow for greater adherence when emotions are heightened and couples are in close quarters. For some couples, a specific plan with tactics for the clinician to interrupt and redirect escalation may be necessary. A couple's unwillingness or inability to heed these interventions may mean a recommendation against utilizing TMH for these types of services (if not a contraindication from couple therapy altogether).

Additionally, the clinician may want to prepare for a member of the couple to walk out of session. Although we are not aware of empirical evidence that speaks to this, many couple therapists we know have anecdotally reported that it seems easier for a client to walk out in TMH. This may be because the individual is typically in their own home, where it may feel more comfortable or common to exit an undesired situation. It is almost always more beneficial to help a person regulate and remain present; however, individuals with lower distress tolerance skills or higher avoidance of conflict could be subject to unplanned walkouts. Making the couple aware of how that will be handled in advance and encouraging each person to remain, unless redirected to step out, can be one way of collaboratively working with emotion. If couples have been taught the time-out skill and the time remaining in session is less than the cooling off or outlet period, clinicians may want to model good use of the skill by calling the couple or each individual at a later time to check in and problem-solve how to handle difficult content in future sessions.

ATTENDANCE

Another distinction between in-person therapy and TMH is the treatment of unplanned absences. While some clinicians move freely between individual and conjoint sessions, and others maintain the conjoint frame exclusively, it is clinically advantageous to have presence or absence planned to whatever extent possible. For instance, as part of clinical assessment, sexual histories may be taken separately with each member of the couple. However, if a conjoint session is planned and one person is not present in the session, there are considerations for both the case conceptualization (e.g., commitment level, motivation for treatment) and for discussing treatment expectations. On the one hand, given the reduction in travel time and resources for TMH when compared to in-person therapy, no-shows to couple therapy may be fewer in number. However, it may also be easy for one member of the couple to log on for a scheduled session while the other is otherwise occupied given that the couple does not need to coordinate travel to the session in advance. In the event that this occurs, it is recommended the clinician speak with the presenting member about the other member's intention to join (e.g., running late vs. not attending). Clinicians that are more concerned with strict maintenance of a conjoint frame may choose to ask the couple to sign on together whenever the late person arrives or to cancel the session should the other person not be attending. Clinicians may remain muted in the virtual room with their video off until the couple signs on again or ask the couple to call when the other person is available.

Institutions may have set guidelines regarding no-shows or late arrivals, while private practitioners have additional flexibility to set their own guidelines in accordance with billing. These policies should be standard across the practice, clearly communicated to clients and can be made to mirror in-person care. Conversely, TMH may also hold value in its ability to engage a partner that is withdrawing or declining to attend the session. If the clinician or other partner can coach the absent individual to attend, session time may be preserved. Any use of coaching toward treatment attendance should be grounded in the case conceptualization (e.g., attention to pursue–withdraw dynamics or the risk of sending the message that one partner is responsible for the attendance of the other).

One consideration regarding attendance that is mostly unique to TMH is when technology problems preclude attendance. In some ways, this is simply another way that external circumstances may prevent couples from attending session, just as if the couple was to experience a last-minute family emergency or a traffic jam on their way to an in-person session. However, at least given the state of communication technology at the time of this writing, technical problems in TMH should be considered the rule rather than exception. Clinicians should have and clearly communicate procedures for dealing with technical problems. If video teleconferencing is not working due to Internet speeds or equipment failure, clinicians may consider using a speakerphone to have an audio-only session instead, but should be aware that many health care organizations and insurance companies do not consider telephone sessions to be billable in the same way as video sessions. Additionally, important visual cues could be lost with an audio-only session, so it is not recommended as a first-line approach. It is also good practice for clients to be sure they have device chargers available and, if possible, a backup device (e.g., a smartphone) if their main device (e.g., a laptop) fails. Clinicians should also have a clear policy regarding whether clients are charged a no-show or late cancellation fee if clients are unable to attend due to technical problems.

CO-LOCATION

One area of consideration that overlaps both the clinical and the logistical is the location of the couple. Many TMH platforms allow for members of a couple not to be co-located, which has its benefits and drawbacks. In some cases, this distance can allow treatment for couples who otherwise cannot receive care (e.g., temporary separation due to caregiving, co-parenting, work schedules). Additionally, if a couple is engaged in a more structured, psychoeducational modality, co-location may be less important. Finally, clinicians may want to consider purposeful distance for distressed couples that have demonstrated difficulties remaining regulated when other interventions (e.g., time-outs, mindfulness exercises) have not been successful. However, depending on setting and resources, clinicians may consider instead a change in approach, such as Fruzzetti's (2006) high-conflict couple dialectical behavior therapy guide or recommending individual services targeting distress tolerance/emotion regulation skills first. Conversely, there can be drawbacks when couples are not co-located. Clinicians utilizing enactments or vulnerable sharing as a clinical intervention may find the effectiveness of this typically powerful interaction tempered when the couple cannot make eye contact and speak to one another directly. Additionally, distance between the couple may collude with avoidance that is present in some withdrawing couples.

DEVICE SELECTION

Finally, device selection for TMH may be especially important in couple therapy. Smaller screens may reduce the field of vision for clinicians and place the couple in close quarters to fit into the screen. It is generally recommended that if a couple has access to a laptop, computer, or tablet of some kind, it can be superior to a smartphone in terms of visual field. Couples that attempt to use phones may also be tempted to pass the phone back and forth depending on who is talking given its size, which may be contrary to the direction the clinician is attempting to direct the session. We have also found that the partner not on camera can be more easily distracted in these situations.

Regulatory and Legislative Considerations

Many clinicians initially wading into use of TMH have questions regarding the legal and regulatory considerations. As of this writing, regulation varies significantly and is changing rapidly between states, agencies, and organizations. Clinicians should seek out specifics in this area from multiple systems, including state licensure boards, professional organizations, insurance panels, and if employed in an agency, any standard operating procedure documents. For instance, federal agencies such as Veterans Affairs allows for certain clinicians to see veterans from any U.S. territory, whereas a university clinic may only be able to provide services within its state. Some progress has been made in creating more uniformed procedures, including interstate compacts (e.g., Psychology Interjurisdictional Compact [PSYPACT]), and it is anticipated that the COVID-19 pandemic may increase adoption of these types of agreements.

Similarly, the rapid improvements in technology make us hesitant to recommend specific platforms. However, clinicians should be attentive to all of the regulatory agencies mentioned earlier, as well as the extent to which the selected platform adheres to security and HIPAA. While the Department of Health and Human Services did issue a temporary waiver for wider platform use (e.g., FaceTime) during the COVID-19 pandemic, it will behoove clinicians to be proactive in selecting the most secure and compliant technology so as to safeguard their clients' privacy and their own ability to practice without fear of legal consequences. Currently, most practitioners who are employed at a larger health care system (e.g., the VA or Kaiser Permanente) use a proprietary TMH platform through that organization, whereas smaller clinics and private practitioners typically use HIPAA-compliant TMH platforms that are either integrated into commercially available electronic health record systems (e.g., SimplePractice) or are stand-alone subscription products (e.g., Doxy.me; VSee.com).

DIGITAL COUPLE INTERVENTIONS

For individual mental health concerns, digital health interventions have emerged as a promising way to provide evidence-based interventions and improve health equity globally (e.g., Muñoz, 2010). Similarly, over the past decade, several DCIs have been developed that have the potential to improve equitable access to effective relationship interventions for couples who need them most.

DCIs further reduce couples' barriers to couple treatment due to scheduling or transportation difficulties because they can be scheduled even more flexibly than TMH. Additionally, because DCIs typically require less provider time than TMH, DCIs significantly reduce financial barriers to couple treatment. Given that many insurance plans do not cover couple therapy, it is often out of the reach of couples that earn even a median household income.

For therapists, expanding their services to include DCIs offers all the benefits of TMH. DCIs also increase the potential number of couples that therapists can work with because (1) therapists generally spend less time per couple and (2) offering DCIs expands therapists' reach to couples that would otherwise not be able or willing to seek traditional couple therapy (even TMH). Additionally, integrating DCIs into their practice has the potential to reduce therapists' required amount of initial training in couple therapy (as we illustrate below)—an important barrier for therapists who were not trained in couple therapy during graduate school.

Finally, DCIs also offer important potential benefits at the societal level. First, there is a large disparity between the number of marriage and family therapists (Bureau of Labor Statistics, 2021) and the number of distressed couples at any given time; there is simply no way for therapists to help all couples in need—even if one were to eliminate all the barriers we have discussed so far. DCIs can help fill this gap. Second, DCIs can significantly improve the cost effectiveness of couple interventions—and they become increasingly cost effective the more couples an organization serves (Georgia Salivar, Rothman, Roddy, & Doss, 2020). Making couple treatment more cost-effective facilitates expanded coverage of these treatments by insurance companies and employee assistance programs.

Types of DCIs

Several types of DCIs are available to couples—automated, guided, and integrated/blended. We first briefly describe the three types before discussing the integrated/blended model in more detail, as we expect that this model will be most useful to couple therapists.

Automated DCIs

In automated DCIs, couples work through the online program or app in a fully self-directed manner, and any reminders or guidance are provided automatically using preprogrammed prompts (e.g., via e-mail or text message). The primary benefit of fully automated DCIs is that they are what researchers have referred to as a "nonconsumable" resource (Muñoz, 2010); that is, they can be used indefinitely by an unlimited number of individuals or couples, and their availability is not limited by staff capacity or the cost to employ coaches. On the other hand, research suggests that couples' program engagement and completion tend to be lower when there is no coaching or guidance provided (e.g., Rothman, Roddy, & Doss, 2019). These lower completion rates may be due in part to a lower bar of entry for couples to begin an automated DCI; couples can begin the program in an exploratory fashion, without having a commitment to complete it. The benefits of fully automated programs in terms of improving accessibility and reach need to be weighed against the limited clinical benefits couples are likely to gain if they do not finish the program. Later, we outline ways that automated DCIs can be utilized as a part of ongoing therapy, which would likely improve completion rates.

Guided DCIs

Guided or coached programs utilize program staff members to provide guidance through the DCI, providing reminders to complete the program material and technical support, and holding brief meetings to reinforce program concepts or provide assistance with difficult content. Because coaching is not therapy, the coach or guide is usually a trainee, paraprofessional, or administrative staff member rather than a licensed clinician. This has the benefit of expanding the available pool of providers for DCIs (given that licensed providers with specialty training in couple interventions are few in number and thus often have limited availability). Paraprofessional or administrative coaches can also provide services for much lower fees than licensed therapists. In addition, unlicensed program staff are not limited by state- or province-specific licensure requirements, which allows DCIs to provide services nationwide and reach geographically remote, rural, and other underserved regions.

Integrated or Blended DCIs

Blended models integrate a DCI into an in-person or TMH couple intervention, such as using an online program or mobile app in conjunction with couple therapy. Blended models are distinct from coached or guided DCIs in that they combine DCIs with traditional relationship interventions provided by a licensed therapist or as part of a formal relationship education program. We now turn to various ways that DCIs can be integrated into traditional interventions.

Integrating DCIs into Treatment

DCIs can be integrated by therapists delivering either individual therapy or couple therapy. Below, we first describe how DCIs can be utilized during a course of individual therapy before providing more specifics on ways couple therapists can use DCIs in couple therapy.

DCIs in Individual Therapy

Relationship problems frequently arise during the course of individual therapy. If the therapist decides to keep the focus of treatment on other topics, encouraging the client to complete an automated DCI can enable the client to make simultaneous gains in both domains. For example, the DCIs we describe in more detail below—ePREP, Hold Me Tight online, and the OurRelationship program—can all be completed by individuals in a relationship (without their partners). Furthermore, many individual therapists bring partners or family members into one or more therapy sessions to provide psychoeducation and address treatment issues such as partner accommodation of symptoms. Therapists could use these opportunities to provide brief coaching to the patient and partner about the skills and information they learned together in the DCI.

If a therapist would like to integrate the client's work in a DCI into the individual therapy session, it is possible to spend about 15 minutes reviewing their progress in the DCI—similar to how review of a homework assignment would typically be handled in therapy. For example, the OurRelationship program has developed guidelines to facilitate this type of integration over the course of four to six individual therapy sessions (*www.ourrelationship.com/therapists/individual-therapy*). In this model, the therapist begins by presenting the rationale for the referral to the OurRelationship program, an overview of the components of the program, and gathering other information about the relationship. In the next session, after the client completes the first phase of the program, the therapist provides feedback on the relationship problem the client selected as a focus. In the third session, the therapist reviews, expands, and deepens the client's understanding of the relationship problem they developed in the DCI. At the end of this session, the therapist helps the client decide whether to share this new understanding of their relationship problem with their partner; if so, this conversation is assigned as homework, and that conversation is debriefed in the following session. Alternatively, the partner can be invited to participate in the therapy session, so that the therapist can be present to help the conversation go smoothly. In the final session, the therapist reviews specific changes the client identified in the DCI that they and their partner can make and encourages the client to modify these changes to increase their effectiveness. If the client desires to share these changes with their partner, that conversation with the partner is debriefed in the subsequent session (or the partner is included in the next therapy session). More specific guidance on this approach can be found on the OurRelationship website (*www.ourrelationship.com/therapists/individual-therapy*).

DCIs in Couple Therapy

DCIs can be used in three ways as part of a course of couple therapy: as a precursor to couple therapy, as an adjunct to couple therapy, or integrated into couple therapy.

PRECURSOR TO COUPLE THERAPY

Couples often enter couple therapy reluctantly, with one partner sometimes figuratively dragging the other into treatment. There are varied reasons for this reluctance—not wanting to discuss issues they consider private with a stranger, concern that the therapist will side with the partner, lack of confidence that treatment will help (and might even make it worse), among others. Some couple therapy approaches, such as integrative behavioral couple therapy (IBCT; see also Chapter 4, in this volume, by Christensen, Dimidjian, Martell, & Doss), address this reluctance by asking couples initially to commit to only four sessions of assessment—postponing the decision about whether to continue into the treatment phase until the end of that fourth session. A DCI preceding a full course of couple therapy can serve many of the same functions. For example, by working with the therapist in a "coaching" role during the DCI (which typically comprises several brief calls), the couple can grow more comfortable revealing issues to the therapist and build confidence in the treatment's conceptualization of their relationship difficulties. After completion of the DCI, the couple and therapist can determine what additional gains could be made in a subsequent, more intensive course of couple therapy. In healthcare system settings, this approach is consistent with a stepped care model. Two of the DCIs with the most empirical support—the OurRelationship program (*www.ourrelationship.com/therapists*) and ePREP (*preponlinetraining.com*), described in more detail below—have guides available to help therapists coach couples through these programs.

ADJUNCT TO COUPLE THERAPY

Automated DCIs can be assigned as a supplement to couple therapy—much in the same way readings or a self-help book would be utilized. However, DCIs have the potential to be more interactive and to provide more accountability for out-of-session completion. The DCI can either reinforce content covered during couple therapy or provide new information on different topics (e.g., mental health) that may be relevant to the couple's presentation but not explicitly during the couple therapy sessions.

Reinforcing or Generalizing Content Covered in Couple Therapy. Automated DCIs focusing on relationship skills can perhaps be most useful in the early stages of couple therapy to increase the initial intervention dosage or to introduce fundamental skills (subsequently reinforced or practiced in session). For example, a therapist who teaches communication skills could assign use of a couples' app for homework, which would allow partners to review the relevant psychoeducation, receive structure and support for the skill practice (e.g., prompts for turn taking), and log their practice sessions. Alternatively, DCIs may be used to add content or skills that are outside the scope of the couple therapy. For example, an automated DCI could help couples work on problem solving a minor issue that is not central to treatment or to help them generalize the skills learned in therapy to other domains such as parent training or co-parenting.

There are several automated DCIs that can be utilized in this way. Perhaps the most notable one is the Couples Coach app (*mobile.va.gov/app/couples-coach*) developed by the National Center for PTSD in collaboration with the VA. This app—available to anyone to download for free from multiple app stores—allows clients to complete activities on their phone or tablet individually as well as jointly with their partner. This high-quality app has five levels that users complete sequentially: (1) observing feelings and behavior, (2) increasing positive interactions, (3) increasing positive communication, (4) working through conflict, and (5) connecting to one's community. A therapist could assign the first two levels for members of a couple to complete on their own (without coordinating with their partner) during the initial assessment phase of couple therapy. Once therapy begins, the third and fourth levels could be used to introduce or reinforce the couple's new communication skills. Unfortunately, the effectiveness of the Couples Coach app—either on its own or in combination with in-person couple therapy—has not yet been examined to our knowledge. Additionally, the Gottman Institute's twitter feed (*https://twitter.com/gottmaninst*) has a wealth of useful information on specific topics that can be provided to couples (see also Chapter 16 on the Gottman method, in this volume, by Gottman & Gottman).

Additional Focus on Individual Mental Health. Given that relationship distress and individual psychopathology are highly comorbid (Whisman, 2013), many couples engaged in couple therapy have concerns about one or both partners' mental health. Couple therapists may want to help the couple address mental health symptoms—particularly if those symptoms contribute to relationship distress or interfere with couple therapy—while maintaining the primary treatment focus on the relationship. In these cases, couples can use a DCI to augment their relationship treatment with self-directed individual mental health programs or apps. Many couples may find this option more affordable and accessible than seeing an individual therapist in addition to couple therapy.

Many free or low-cost mental health apps and programs are based on evidence-based principles. These programs are generally equally effective as in-person therapies (Andersson, Titov, Dear, Rozental, & Carlbring, 2019). In selecting digital programs to recommend to their clients, couple therapists are encouraged to select tools based on "gold standard" psychotherapeutic interventions (e.g., cognitive-behavioral therapy, mindfulness-based therapy, exposure therapy). Several reputable organizations maintain "digital apothecaries" or online repositories of currently available online programs and apps—sometimes including expert evaluations. We have included a list of several of these repositories in the "Suggestions for Future Research" section at the end of this chapter.

In addition to assigning an automated app/program as homework, couple therapists may consider referring the couple to a guided couples program targeting individual mental health rather than referring them to individual therapy. For example, Couple HOPES (*www.couplehopes.com*) is a guided online program based on a brief version of cognitive-behavioral conjoint therapy (CBCT) for PTSD, a couple-based treatment for individuals with PTSD and their partners (see also Chapter 24 on PTSD, in this volume, by Monson & Fredman). Couple HOPES targets both relationship functioning and PTSD symptoms.

INTEGRATED INTO COUPLE THERAPY

We believe one of the most exciting applications of a DCI is for therapists to blend it into couple therapy as an integral part of treatment. This model is somewhat analogous to the "flipped classroom" model that has become more common in university teaching. Rather than relying on the instructor to present information (typically in lecture format), the information is provided through other means outside of the classroom (via videos or readings); the instructor then spends class time discussing the information and helping the students achieve a deeper and more nuanced understanding of the material. There are several advantages to this model. First, it has the potential to reduce the length of a course of couple therapy, which in turn can help overcome important financial (e.g., lack of insurance coverage) and logistical (e.g., transportation, work schedules) barriers to treatment. Second, introducing concepts outside of the session—often without the partner present—can allow individuals time to reflect on the ideas and potentially reduce the negative emotions in the therapy room. Third, using a DCI can assist the therapist in conveying key pieces of information that may be less familiar to them—something that may be especially helpful for therapists early in their career or for more established therapists with primary training in individual therapy. Fourth, some DCIs are tailored for specific populations of couples with which the therapist has less experience; for example, the OurRelationship program has a version culturally tailored for same-gender couples (*www.ourrelationship.com/same-gender*) and a version tailored for military couples (*www.ourrelationship.com/military-couples*).

There are several DCIs that could potentially be integrated into a course of couple therapy. For therapists providing EFCT (see also Chapter 6, in this volume, by Johnson et al.), the online adaptation of the Hold Me Tight Online (*www.holdmetightonline.com*) program might be a viable option. For therapists working in an integrative behavioral (see Chapter 4 on IBCT, in this volume, by Christensen et al.) or the cognitive-behavioral couple therapy model (see Chapter 3 on CBCT, in this volume, by Baucom, Epstein, Fischer, Kirby, & LaTaillade), incorporating the ePREP or OurRelationship programs into treatment may be useful. Here, we focus on integrating the OurRelationship program into couple therapy because, to our knowledge, it is the only DCI with a detailed plan for this type of integration.

Model for Integrating the OurRelationship DCI into Couple Therapy

The standard model for integrating the OurRelationship program into a course of couple therapy includes the 7-hour program plus approximately eight sessions of couple therapy. We present an overview of this plan to help illustrate the exciting ways in which integrating DCIs may facilitate delivery of brief versions of couple therapy without sacrificing their efficacy. Therapists interested in implementing this plan are encouraged to consult more detailed descriptions published elsewhere (Christensen, Doss, & Jacobson, 2020; Le, Rothman, Christensen, & Doss, 2021) and available on the OurRelationship website (*www.ourrelationship.com/therapists/couple-therapy*).

SESSION 1

In this conjoint intake session, the therapist works to understand the couple's presenting problems, as well as their relationship strengths. At the end of the session, the therapist describes the OurRelationship program, the rationale for integrating it into couple therapy, and helps the couple come to a decision about whether they would like to work on the same relationship issues or two separate relationship issues during the OurRelationship program.

Before Session 2, the couple completes the Observe phase of the OurRelationship program. In this phase, each partner answers a brief assessment questionnaire about their relationship functioning and receives feedback on both the relative strengths and challenges of their relationship. They then pick labels for the relationship issue(s) they want to work on and learn the speaker–listener communication structure.

SESSION 2

In this second session, the therapist first meets with each partner individually for 20 minutes to assess sensitive issues (e.g., IPV, ongoing affairs, or mental health issues) and hears each partner's individual perspective on their relationship difficulties. In the final 10 minutes of the session, the therapist (1) describes the next phase of the OurRelationship program and (2) plans for whether the partners will share their DEEP understandings (described next) with each other before the next session or wait to share during the session.

In the Understand phase of the program, each member of the couple separately completes activities to help them develop a DEEP understanding of their relationship issues—how natural Differences, hidden Emotions, External stressors, and Patterns of communication are creating or exacerbating their struggles. In each of these four components, couples view educational activities (with videos of example couples illustrating the component) and are then asked to consider how the component is playing a role in their own relationship. In most cases, couples see feedback on their own relationship to guide this exploration. For example, in the Differences section, users see how they and their partners scored on standard measures of personality, emotional expressiveness, and comfort with closeness. If couples choose to share their DEEP understandings with each other before the next section, they complete a conversation activity in which the program structures a speaker–listener conversation and displays what each partner had selected/written earlier in the program.

SESSION 3

In this session, the therapist works to solidify couples' DEEP understandings. If the couple has already had a conversation via the program to share these understandings, the therapist first debriefs the conversation. On the one hand, if it went well, the therapist can heighten that experience (what IBCT calls "empathic joining") with questions such as "What was it like to share that with your partner?" If the couple struggled in the conversation, it can be an opportunity for them to engage in what IBCT calls "unified detachment" by applying the DEEP understanding to see where the conversation went wrong. After debriefing the conversation, the therapist can inquire about the components of the DEEP understanding the couple picked and provide further insight into these factors.

On the other hand, if the couple waited to share their DEEP understandings (as is recommended with more volatile couples), they can log into their mobile device in session and launch the program's conversation activity. Each partner then takes turns being the speaker (following the standard speaker–listener guidelines) for each of the four components. After both partners have had a chance to be speaker for Differences (the first component), the therapist can add any relevant information from their own formulation of the couple. This sequence would continue for the remaining three components.

SESSIONS 4 AND 5

The goal of these sessions is to solidify the couple's DEEP understanding of their relationship difficulties. This can be done through a combination of debriefing interactions that go poorly, understanding (and celebrating) interactions that seem to be going better, and fleshing out the couple's DEEP understanding. These sessions are also an opportunity for therapists working in alternative therapy models to add material consent with those orientations. For example, emotionally focused therapists might want to work with partners to reveal their unvoiced attachment needs and further enhance emotional intimacy by creating important softening moments. Therapists working in Gottman's model of couple therapy might want to provide feedback on meta-emotion mismatches and work to construct a shared meaning system.

Once couples have achieved a "collaborative set"—willingness to work together to solve the relationship problem rather than focus primarily on winning the next argument—they are ready to move to the Respond phase of the OurRelationship program. At this point, the therapist introduces the Respond phase and assigns the phase as homework. This phase of the program helps couples identify which parts of their DEEP understanding might be better targets for acceptance, and which are amenable to direct change efforts. The program then helps each partner brainstorm ideas for how they can improve their patterns of communication, as well as the specific relationship problems they chose. As with the Understand phase, couples have the option to share their ideas as part of the program (in a structured problem-solving conversation) or wait to share their ideas in the next therapy session.

SESSION 6

The therapist's goal in this session is to ensure that the changes couples select are specific, achievable, and address the underlying issue(s) with which they struggle. If the couple shared their ideas for change before the session, the therapist should begin by debriefing that conversation before moving to review the changes that were selected. If the couple waited for the session to share the changes they each decided on, they would log in to their mobile device and utilize the program activity (displaying what they had written in earlier activities) to facilitate the problem-solving conversation. As in the third session, the therapist can add their own ideas and suggestion after each idea is presented.

For homework, the couple is asked to complete the "Acting on your Plan" activity, which reviews many of the common barriers to successfully enacting deliberate change. In this activity, couples are asked to consider the types of difficulties they will encounter (both to prevent difficulties and to normalize these challenges).

SESSION 7

Typically, couples can partially enact some of the changes they selected while struggling with other changes. Therapists can use this session to reinforce the changes that have gone well and solidify these changes by helping the couple conceptualize how the change modified their DEEP understanding. For those changes that have not gone well, therapists can help normalize these struggles and work with the couple to decide whether modifications to the changes are necessary or whether they would like to continue in their change efforts.

SESSION 8

This session seeks to accomplish traditional termination goals—helping couples understand and celebrate the gains that they have made during treatment, instilling hope for the future of their relationship, and inoculating them against challenges that they will likely continue to encounter. The optional Strengthen phase of the OurRelationship program should also be introduced; in this phase, the couple can choose to work on additional relationship issues and get more resources on other topics.

State of the Research on DCI for Couples

Several DCIs have been evaluated in research studies that test their impacts on both relationship functioning and individual well-being. Below, we divide the DCIs into their level of empirical support as defined by Chambless and Hollon (1998).

Probably Efficacious DCIs

The most well-researched DCIs to date are the OurRelationship program (*www.ourrelationship.com*), an adaptation of IBCT, and the ePREP program (*www.lovetakeslearning.com*), an online adaptation of the PREP relationship education program (see Chapter 29, "Relationship Enhancement and Distress Prevention," in this volume, by Carlson, Rhoades, Johnson, Stanley, & Markman).

The first studies of a computer-based version of ePREP were conducted with individual college students in a laboratory setting. These studies showed ePREP produced improvements in depression, anxiety, relationship aggression, and other aspects of relationship functioning that were comparable to a computer-based prevention program focused on individual mental health (Braithwaite & Fincham, 2007) and had large effect sizes compared to an educational placebo condition (*d*'s = 0.7 to 2.7; Braithwaite & Fincham, 2009). Subsequent studies of computerized ePREP with couples recruited from both university and community settings showed significant impacts on relationship satisfaction and functioning, depression and anxiety, and IPV (Braithwaite & Fincham, 2011, 2014); improvements in IPV among community couples were maintained for 1 year following the intervention (Braithwaite & Fincham, 2014). These studies also showed that the couples who were most engaged and gained the most mastery of program concepts experienced the greatest benefits (Braithwaite & Fincham, 2011).

The original study of OurRelationship was a large randomized clinical trial (RCT) of 300 couples recruited across the United States. This study showed that a guided version of the online OurRelationship program had significant medium to large impacts (*d*'s = 0.4 to 0.9) on both relationship functioning (e.g., satisfaction, conflict) and individual well-being (e.g., depressive symptoms) relative to a wait-list control, with 86% of couples completing the program and high ratings of program satisfaction (Doss et al., 2016). These gains were maintained for a year following the program (Doss, Roddy, Nowlan, Rothman, &

Christensen, 2019). Although OurRelationship can be completed in a fully automated format, couples in this study received four coaching calls, and a follow-up RCT showed that receiving these four coach calls throughout the OurRelationship program doubled the completion rate compared to just one initial introductory call (Roddy, Rothman, & Doss, 2018).

Recently, a large national trial tested guided versions of both the OurRelationship and ePREP programs among 742 low-income couples across the United States. In this study, both programs showed medium-sized effects (median $d = 0.46$) on several measures of relationship functioning and individual wellbeing (Doss et al., 2020; Roddy, Rhoades, & Doss, 2020) that were maintained for a year following the program (Roddy, Knopp, Georgia Salivar, & Doss, 2021). Sixty-nine percent of couples completed the program, and ratings of program satisfaction were high (Doss et al., 2020). There were no significant differences between the ePREP and OurRelationship programs on most outcome variables; however, couples in the OurRelationship program reported slightly larger effect sizes than couples in ePREP for improvements across all outcomes and significantly greater declines in communication conflict.

Possibly Efficacious DCIs

Power of Two (*www.poweroftwomarriage.com*) provides a combination of online relationship education programming, other multimedia, and coaching. A version of this program combined with a self-help book was tested in a sample of couples during the postpartum period (Kalinka, Fincham, & Hirsch, 2012). Results indicated that the program plus book resulted in significant improvements in relationship satisfaction and more effective arguing relative to the control group. To our knowledge, the Power of Two program has not been tested in other studies or populations.

Experimental DCIs

The research base on other DCIs is less robust at present, but there are a number of other DCIs that show promise. Hold Me Tight online (*www.holdmetightonline.com*) is a new online implementation of the Hold Me Tight (HMT) relationship education program, which is based on EFCT, an evidence-based couple therapy. Although no studies of the online program have yet been conducted, the in-person version of HMT delivered in a weekly or weekend retreat format has been shown to benefit relationship satisfaction and trust (Kennedy, Johnson, Wiebe, Willett, & Tasca, 2019), and has also shown positive impacts in Dutch (Conradi, Dingemanse, Noordhof, Finkenauer, & Kamphuis, 2018) and Chinese (Wong, Greenman, & Beaudoin, 2018) samples.

The RELATE online relationship inventory (*http://relatefoundation.com*) is based on a premarital assessment and counseling framework. It uses an assessment of both strengths and areas for improvement to help couples enhance their satisfaction, commitment, and readiness for marriage (Larson, Vatter, Galbraith, Holman, & Stahmann, 2007).

Clinical and Regulatory Considerations in Using a DCI

Integrating DCIs into one's practice requires consideration of several legal and ethical issues that extend beyond those typically considered for in-person therapy. We explore several of those considerations below. However, it is important to note that there were a number of regulation changes resulting from the COVID-19 pandemic, so it is important for readers to consider whether those changes continue to persist. (See also Chapter 31 on ethical issues, in this volume, by Margolin, Gordis, & Rasmussen, for further discussion of ethical legal issues not directly related to DCIs.)

License Jurisdiction

We have presented several ways in which DCIs can be integrated into a clinical practice. A key distinction is whether the therapist is providing "therapy" or "coaching." If the couple is a therapy client (e.g., using the DCI by integrating it into a course of couple therapy or other services that would otherwise require a license to provide), then one must ensure that one's license covers the geographic area in which the couple is located. (We previously described licensure considerations in detail in the section on TMH.) However, if one is serving solely as a "coach" for the DCI and has not entered into a therapy relationship with the client, such license restrictions may not apply. Because the distinction between a provider serving as a therapist versus a coach is not often clear to the couple, we recommend conducting a formal informed consent process to explain the provider's role (and to document this consent process).

Confidentiality Protections

Ensuring confidentiality is important whether one works with couples in a therapist or a coaching role; however, HIPAA and related requirements increase the stringency of these considerations. We discussed HIPAA and related confidentiality considerations for streaming video in the section on TMH. However, with a DCI, there is the additional consideration of the security of any data stored within the DCI. There are three general approaches that therapists can take when working with a DCI when HIPAA compliance is necessary. The first is to ask clients to use a DCI that does not collect any personal health information (PHI); the previously discussed Couples Coach app to augment couple therapy with extra skills is one example of this approach. The second is to ask couples not to enter PHI into the DCI (either by omitting things such as last names and e-mails or, if they are required fields, entering incorrect information). Third, if PHI is required for the program to operate correctly, it is possible for clients to maintain control over those data without the therapist having direct access to it. For example, a DCI can be assigned as homework—much as a self-help book or workbook would be. Even if the DCI is brought into session on a phone (as we previously described in the model for integration into couple therapy), it is possible for the couple to maintain control of that data if the therapist does not have access to their account. As of this writing, we are not aware of any DCIs that are fully HIPAA-compliant (although some are HITECH [Health Information Technology for Economic and Clinical Health]-compliant), in part because this compliance raises barriers to participation such as dual authentication and messaging restrictions. We are hopeful that some DCIs—including the OurRelationship program—will be HIPAA-compliant in the new few years.

Emergencies and Mandatory Reporting

In the TMH section, we previously discussed necessary considerations in handing emergency situations such as domestic violence, suicidal ideation, and child/elder adult abuse. There are two special considerations to consider when working with a couple through a DCI. First, unlike TMH, much of the intervention delivery occurs asynchronously; as such, the therapist cannot assume that they will present when the emergency is reported. Therefore, the therapist should ensure that the DCI will respond automatically with directions for the couple to contact the relevant hotline (e.g., the National Domestic Violence Hotline or the National Suicide Prevention Lifeline). If this is not possible, then the therapist should provide this information to the couple ahead of time. The second consideration when using a DCI in a coaching (rather than therapist) role is that if a couple is residing outside of the jurisdiction in which the therapist is licensed, the mandatory reporting requirements may differ. For example, states define "elder/vulnerable adult abuse" differently, with some states focusing more on limited capability while others focus on age. There are several online collections of state laws regarding elder abuse (*https://ncea.acl.gov/resources/state.aspx*) and child abuse (*www.childwelfare.gov/topics/systemwide/laws-policies/state*).

FUTURE DIRECTIONS

It is exciting to consider the various directions the use of technology in couple therapy may head. In this section, we first review the unanswered questions that existing technology has already raised before turning to future developments in technology itself.

Effectiveness of Some Technology Applications

In this chapter, we have focused on established applications of technology that have a strong research base. Telehealth has repeatedly been shown to be effective and to maintain important aspects of the therapeutic alliance in individual therapy (Berryhill et al., 2019; Varker et al., 2019). Additionally, couple therapy conducted via TMH has become commonplace within the VA (e.g., Fischer, Bhatia, Baddeley, Al-Jabari, & Libet, 2018). However, much less is known about the effectiveness of telehealth to deliver couple therapy in the community—which will rely on a less developed technology infrastructure. Although we have included numerous considerations for couples and therapists in this chapter that should maximize its effectiveness, studies should explore this modality when delivered within the community.

Additionally, we have reviewed several DCIs with demonstrated effectiveness when delivered as a guided intervention—most notably the ePREP and OurRelationship programs (Doss et al., 2020). However, nothing is currently known about how effective these interventions are when delivered as an adjunct to individual therapy or when integrated into an ongoing course of couple therapy. It will be important to test various models of integration to maximize their efficacy. Additionally, as yet unexplored is the efficacy of guided DCIs as a precursor to couple therapy and as a tool following couple therapy to maintain gains. Efficacy and effectiveness studies along these lines will be important to inform a stepped-care model of couple therapy.

Moderators of Technology Applications

There are likely couples for whom technology will accentuate the effects of couple therapy. For example, some types of couples or individuals may appreciate the ability to acquire and digest new skills or knowledge before having to apply them in session with the partner. Other couples may be more able to understand and apply lessons learned via a DCI to their own relationship; therefore, they may be more likely to benefit from a stepped-care or integrated model of couple interventions. Other couples will be more frequently confronted by logistical, financial, or psychological barriers to in-person couple therapy and thus derive more benefit from the therapist's use of technology to overcome these barriers. However, it is important to also consider that, for some couples, use of technology, as we have outlined in this chapter, may reduce benefits that they would have received from in-person couple therapy (see discussions regarding co-location and contraindication). For example, the barriers to technology use for older couples (who may be less agile with technology) and lower-income and rural couples (who may have more barriers to high-speed Internet access) may outweigh the barriers to in-person couple therapy. Identifying these couples—and addressing their barriers—will be essential in ensuring that they receive the most effective treatment possible.

It is also important to recognize that certain types of couple therapists and couple therapy approaches may benefit more from the use of technology. Previously, we speculated that technology may be more beneficial for beginning therapists (who themselves use technology more innately) and therapists who are relatively inexperienced in couple therapy or working with certain types of couples (as the technology can be used to explain key concepts, provide structured practice for the couple, and potentially reduce the couple's negative emotions in the room). However, this idea has not been tested; there may also be other therapist factors that moderate technology's effectiveness. Certain couple therapy approaches and techniques also seem more amenable to use of technology. In our own experience of translating IBCT for the OurRelationship program, for example, the technique of unified detachment was effectively captured by helping couples create and share their DEEP understandings. However, another IBCT technique—empathic joining—was more difficult to incorporate into the online program because it benefits from the therapist heightening the vulnerable emotional experiences of each partner, then facilitating the sharing of those emotions between partners (Doss, Benson, Georgia, & Christensen, 2013). Therefore, couple therapy orientations that rely more on the couple acquiring knowledge or skills may be more amenable to translation into technology applications than orientations that rely more on process interventions with the therapist (e.g., enactments in EFCT) or insight-oriented interventions (see Chapter 7, "Object Relations Couple Therapy," in this volume, by Siegel). However, with the recent development of the online version of Hold Me Tight (*www.holdmetightonline.com*), we hope that at least the EFCT model will also be effective with less intensive therapist involvement. Finally, we have proposed in several places in this chapter that having couples utilize this technology in their own homes may help with generalization; this is an area for additional examination.

Leveraging Technology to Increase Reach of Couple Interventions

One of the most exciting advantages of technology for couple interventions is its potential to expand the reach of couple therapy. While there have already been notable advances in this domain, important work remains. What is the best way to make couples aware of these types of interventions—either as a stand-alone program or as an entrée into couple therapy?

Even more work is required to increase the uptake of technology by couple therapists. What is the best way to make therapists aware of, and excited about, the potential of leveraging technology in their practice? What training models are necessary? And given that community therapists have not been centrally involved in the development or testing of technological applications for couple therapy, what additional advances could be made to meet the need of couple therapists?

Finally, how can technology be leveraged to gain the support of third-party payers for couple interventions, including couple therapy? To make strides in achieving this goal, we suspect that the cost–benefit (i.e., showing that an intervention saves an organization money) and cost-effectiveness (i.e., showing that an intervention saves more money than another intervention) of couple interventions will need to be demonstrated. Technology can help this effort in two ways. First, automated and guided DCIs—because of the larger number of couples that they serve—can greatly expand the domains that couple interventions are known to improve. For example, the OurRelationship and ePREP programs have been shown to improve numerous domains of mental and physical health (Roddy et al., 2020). Depression (which shows medium-size decreases in these programs) alone costs over $200 billion a year in the United States (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015). Second, the fact that DCIs have been shown to be more cost-effective when compared with intensive couple therapy (Georgia Salivar et al., 2020) will make the cost savings of couple interventions even more attractive to third-party payers.

Application of Cutting-Edge Technology to Couples

Although this chapter has focused on application of existing, widely available technology, the technological advances on the horizon of health care technology may have useful applications with couples. Wearable technology, such as smart watches, fitness trackers, and biosensors, can rapidly detect information about a person's physiological state, allowing mobile or online health tools to intervene or respond in real time. For couples, wearable sensors could be linked with an app that provides time-out instructions or other conflict management strategies when couples display elevated stress markers. Unfortunately, there are no commercially available wearable DCIs yet, but we anticipate these approaches may be the next major advance in DCIs.

Machine learning and artificial intelligence (AI) also have the potential to enhance the effectiveness of automated DCIs. Mental health chatbots, such as Replika and Woebot, have already been developed to provide responsive, automated cognitive-behavioral intervention for individual psychological concerns. These AI tools use natural language processing and machine learning to detect key words or phrases and provide empathic responses or useful strategies. Although no AI-based DCIs for couples exist at present, several are under development (e.g., Motalebi & Abdullah, 2018). Chatbot technology could ultimately enable DCIs to tailor program content to a couple's specific case conceptualization or to respond empathically to an emotional experience shared by a partner.

Finally, there are some commercially available, wearable and biosensor products designed to help couples stay connected from a distance. For example, the Pillow Talk wristband detects the wearer's heartbeat and transmits it to a speaker placed under their partner's pillow, mimicking the experience of hearing a partner's heartbeat while cuddling. The HB Ring shares a partner's heartbeat via pulses to the wearer's finger. And for long-distance partners wanting to keep their sexual connection alive, there are several product lines of paired erotic toys that couples can control remotely for one another. Although none of these tools has yet been evaluated as clinical tools for couples, couple therapists may eventually be able to use these wearable tools to help couples enhance intimacy and nonverbal communication—for example, to enhance the sensate focus sex therapy technique (see also Chapter 19 on sexuality, in this volume, by Hall and Watter).

CONCLUDING COMMENTS

The rapid pace of technological innovation reflects the exciting advances and promise of technology in the delivery of couple interventions. Telehealth has the important advantages of reducing geographical and logistic barriers to couple therapy. DCIs have the potential to substantially increase the reach of interventions to couples that would be unlikely to receive traditional couple therapy—or might receive it too late. Although already promising, this field presents numerous questions for further exploration.

However, a natural extension of the rapidly evolving nature of technology is that this chapter will likely have the dubious distinction of being the most outdated of all the chapters in this *Handbook* by the next edition. Because we have focused here on uses of existing technologies, we expect that most of this datedness will result from our failure to anticipate novel innovations and applications to couple therapy, rather than our forecasting things that do not evolve. We look forward to the widespread application of today's technology and to the future development of technology not yet on the horizon.

SUGGESTIONS FOR FURTHER STUDY

- Ethics of providing remote interventions: American Association for Marriage and Family Therapy's Code of Ethics (2015): *www.aamft.org/legal_ethics/code_of_ethics.aspx*
- Updated practice guidelines for telehealth: *www.apaservices.org/practice*
- Resources to select an app focused on mental health:
  - American Psychiatric Association: *www.psychiatry.org/psychiatrists/practice/mental-health-apps*
  - One Mind PsyberGuide: *https://onemind-psyberguide.org*
  - Veterans Affairs: *https://mobile.va.gov/appstore*
  - U.K. National Health Service: *www.nhs.uk/apps-library*
- Guidance for integrating a DCI into a course of therapy: *www.ourrelationship.com/therapist*

REFERENCES

Andersson, G., Titov, N., Dear, B. F., Rozental, A., & Carlbring, P. (2019). Internet-delivered psychological treatments: From innovation to implementation. *World Psychiatry, 18,* 20–28.

Berryhill, M. B., Culmer, N., Williams, N., Halli-Tierney, A., Betancourt, A., Roberts, H., & King, M. (2019). Videoconferencing psychotherapy and depression: A systematic review. *Telemedicine Journal and E Health, 25,* 435–446.

Braithwaite, S. R., & Fincham, F. D. (2007). ePREP: Computer based prevention of relationship dysfunction, depression and anxiety. *Journal of Social and Clinical Psychology, 26,* 609–622.

Braithwaite, S. R., & Fincham, F. D. (2009). A randomized clinical trial of a computer based preventive intervention: Replication and extension of ePREP. *Journal of Family Psychology, 23,* 32–38.

Braithwaite, S. R., & Fincham, F. D. (2011). Computer-based dissemination: A randomized clinical trial of ePREP using the actor partner interdependence model. *Behaviour Research and Therapy, 49,* 126–131.

Braithwaite, S. R., & Fincham, F. D. (2014). Computer-based prevention of intimate partner violence in marriage. *Behaviour Research and Therapy, 54,* 12–21.

Bureau of Labor Statistics. (2021, January 25). Marriage and family therapists. *Occupational outlook handbook.* www.bls.gov/ooh/community-and-social-service/marriage-and-family-therapists.htm.

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process, 59,* 974–988.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7–18.

Christensen, A., Doss, B. D., & Jacobson, N. S. (2020). *Integrative behavioral couple therapy: A therapist's guide to creating acceptance and change.* New York: Norton.

Conradi, H. J., Dingemanse, P., Noordhof, A., Finkenauer, C., & Kamphuis, J. H. (2018). Effectiveness of the "Hold Me Tight" relationship enhancement program in a self-referred and a clinician-referred sample: An emotionally focused couples therapy-based approach. *Family Process, 57,* 613–628.

Doherty, W. J., Harris, S. M., Hall, E. L., & Hubbard, A. K. (2021). How long do people wait before seeking couples therapy?: A research note. *Journal of Marital and Family Therapy, 47,* 882–890.

Doss, B. D., Benson, L. A., Georgia, E. J., & Christensen A. (2013). Translation of integrative behavioral couple therapy to a web-based intervention. *Family Process, 52,* 139–153.

Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based OurRelationship program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology, 84,* 285–296.

Doss, B. D., Knopp, K., Roddy, M. K., Rothman, K., Hatch, S. G., & Rhoades, G. K. (2020). Online programs improve relationship functioning for distressed low-income couples: Results from a nationwide randomized controlled trial. *Journal of Consulting and Clinical Psychology, 88,* 283–294.

Doss, B. D., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2009). Marital therapy, retreats, and books: The who, what, when, and why of relationship help-seeking. *Journal of Marital and Family Therapy, 34,* 527–538.

Doss, B. D., Roddy, M. K., Nowlan, K. M., Rothman, K., & Christensen, A. (2019). Maintenance of gains in relationship and individual functioning following the online OurRelationship program. *Behavior Therapy, 50,* 73–86.

Fischer, M. S., Bhatia, V., Baddeley, J. L., Al-Jabari, R., & Libet, J. (2018). Couple therapy with veterans: Early improvements and predictors of early dropout. *Family Process, 57,* 525–538.

Fruzzetti, A. (2006). *The high-conflict couple: A dialectical behavior therapy guide to finding peace, intimacy, and validation.* Oakland, CA: New Harbinger.

Gassova, Z., & Werner-Wilson, R. J. (2018). Characteristics of e-therapy websites involving marriage and family therapists. *American Journal of Family Therapy, 46*(1), 27–43.

Georgia, E. J., & Doss, B. D. (2013). Web-based couple interventions: Do they have a future? *Journal of Couple and Relationship Therapy, 12,* 168–185.

Georgia Salivar, E. J., Rothman, K., Roddy, M. K., & Doss, B. D. (2020). Relative cost effectiveness of in-person and internet interventions for relationship distress. *Family Process, 59,* 66–80.

Greenberg, P. E., Fournier, A. A., Sisitsky, T., Pike, C. T., & Kessler, R. C. (2015). The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *Journal of Clinical Psychiatry, 76,* 155–162.

Gross, D. F., Lancaster, C. L., López, C. M., & Acierno, R. (2018). Treatment satisfaction of home-based telehealth versus in-person delivery of prolonged exposure for combat-related PTSD in veterans. *Journal of Telemedicine and Telecare, 24,* 51–55.

Harold, G. T., & Sellers, R. (2018). Interparental conflict and youth psychopathology: An evidence review and practice focused update. *Journal of Child Psychology and Psychiatry, 59,* 374–402.

Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191.

Hertlein, K. M., Eddy, B. P., & Lancaster Strickland, M. (2020). A framework for assessing technology-mediated IPV. *Journal of Couple and Relationship Therapy, 19,* 296–321.

Jarnecke, A. M., Ridings, L. E., Teves, J. B., Petty, K., Bhatia, V., & Libet, J. (2020). The path to couples therapy: A descriptive analysis on a veteran sample. *Couple and Family Psychology: Research and Practice, 9,* 73–89.

Johnson, C. A., Stanley, S. M., Glenn, N. D., Amato, P. R., Nock, S. L., Markman, H. J., & Dion, M. R. (2002). *Marriage in Oklahoma: 2001 baseline statewide survey on marriage and divorce* (S02096OKDHS). Oklahoma City: Oklahoma Department of Human Services.

Kalinka, C. J., Fincham, F. D., & Hirsch, A. H. (2012). A randomized clinical trial of online-biblio relationship education for expectant couples. *Journal of Family Psychology, 26,* 159–164.

Kennedy, N., Johnson, S. M., Wiebe, S. A., Willett, J. B., & Tasca, G. A. (2019). Conversations for connection: An outcome assessment of the Hold Me Tight relationship education program, and recommendations for improving future research methodology in relationship education. *Journal of Marital and Family Therapy, 45,* 431–446.

Larson, J. H., Vatter, R. S., Galbraith, R. C., Holman, T. B., & Stahmann, R. F. (2007). The relationship evaluation (relate) with therapist-assisted interpretation: Short-term effects on premarital relationships. *Journal of Marital and Family Therapy, 33,* 364–374.

Le, Y., Rothman, K., Christensen, A., & Doss, B. D. (2021). Integrating the online OurRelationship program into a stepped care model of couple therapy. *Journal of Family Therapy, 43,* 215–231.

Lopez, A., Schwenk, S., Schneck, C. D., Griffin, R. J., & Mishkind, M. C. (2019). Technology-based mental health treatment and the impact on the therapeutic alliance. *Current Psychiatry Reports, 21,* 76.

Morland, L. M., Knopp, K., Macdonald, A., Khalifian, C., Grubbs, K., Mackintosh, M.A., . . . Glynn, S. (2020, November). *RCT of brief telehealth and in-person couples' treatment for PTSD.* Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Philadelphia.

Morland, L. A., Mackintosh, M., Glassman, L. H., Wells, S. Y., Thorp, S. R., Rauch, S. A. M., . . . Acierno, R. (2020). Home-based delivery of variable length prolonged exposure therapy: A comparison of clinical efficacy between service modalities. *Depression and Anxiety, 37,* 346–355.

Motalebi, N., & Abdullah, S. (2018, May). Conversational agents to provide couple therapy for patients with PTSD. *ACM International Conference Proceeding Series,* 347–351.

Muñoz, R. F. (2010). Using evidence-based Internet interventions to reduce health disparities worldwide. *Journal of Medical Internet Research, 12,* 1–10.

Roddy, M. K., Knopp, K., Georgia Salivar, E., & Doss, B. D. (2021). Maintenance of relationship and individual functioning gains following online relationship programs for low-income couples. *Family Process, 60,* 102–118.

Roddy, M. K., Rhoades, G. K., & Doss, B. D. (2020). Effects of ePREP and OurRelationship on low-income couples' mental health and health behaviors: A randomized controlled trial. *Prevention Science, 21,* 861–871.

Roddy, M. K., Rothman, K., Cicila, L. N., & Doss, B. D. (2019). Why do couples seek relationship help online?: Description and comparison to in-person interventions. *Journal of Marital and Family Therapy, 45,* 369–379.

Roddy, M. K., Rothman, K., & Doss, B. D. (2018). A randomized controlled trial of different levels of coach support in an online intervention for relationship distress. *Behaviour Research and Therapy, 110,* 47–54.

Rothman, K., Roddy, M. K., & Doss, B. D. (2019). Completion of a stand-alone versus coach-supported trial of a web-based program for distressed relationships. *Family Relations, 68,* 375–389.

Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. *Psychological Services, 16,* 621–635.

Whisman, M. A. (2013). Relationship discord and the prevalence, incidence, and treatment of psychopathology. *Journal of Social and Personal Relationships, 30,* 163–170.

Wong, T. Y., Greenman, P. S., & Beaudoin, V. (2018). "Hold Me Tight": The generalizability of an attachment-based group intervention to Chinese Canadian couples. *Journal of Couple and Relationship Therapy, 17,* 42–60.

Wrape, E. R., & McGinn, M. M. (2019). Clinical and ethical considerations for delivering couple and family therapy via telehealth. *Journal of Marital and Family Therapy, 45*(2), 296–308.

CHAPTER 31

Ethical Issues in Couple Therapy

Gayla Margolin, Elana B. Gordis, and Hannah F. Rasmussen

Conducting therapy with couples as contrasted with individuals is more complicated, yet it can be a more rewarding and efficient way to create change in the couple relationship, the individual partners, and the larger family system. With the potential for high therapeutic impact, couple therapy also is more susceptible to ethical dilemmas and missteps, particularly for therapists accustomed to conducting individual therapy. The context of couple therapy—simultaneously working with two clients who typically present with seemingly competing, if not outright incompatible, goals—poses both therapeutic and ethical challenges. Therapeutically, couple therapy entails a constant yet often imperceptible balancing among several priorities: working toward relationship goals, maintaining a beneficial relationship with each partner, and taking into account the well-being of each of those individuals. Ethically, therapists' mandate to "benefit those with whom they work and take care to do no harm" (Principle A; American Psychological Association, 2017a, p. 3) requires the consideration of the welfare and protection of two persons whose lives are intimately entwined—a decidedly more complex matter than understanding and applying our professional ethical standards to one autonomous individual. We further contend that our ethical responsibility as couple therapists also extends to those whose well-being is interconnected with the couple relationship, with dependent children being the principal, but not the only, example.

This chapter identifies ethical issues in couple therapy, with particular attention to how therapeutic processes in couple therapy pose unique challenges in ethical decision making. Legal regulations, as well as therapists' and clients' values, further intersect with these considerations. As with ethical challenges in any therapeutic modality, the nuance of situations may preclude easy rules pointing to one correct answer when ethical dilemmas arise. Whereas couple therapists need to abide by ethical principles of their discipline (e.g., Ethical Principles and Code of Conduct from the American Psychological Association, 2017a; Code of Ethics from the American Association for Marriage and Family Therapy, 2015; Code of Ethics from the National Association of Social Workers, 2017), commonalities arise in the ethical dilemmas that couple therapists from various disciplines tend to encounter. Moreover, rather than absolutes steering clinicians' ethical decision making, we have, for example, "guidelines [that] are not intended to be mandatory or exhaustive and may not be applicable to every professional or clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists" (American Psychological Association, 2002, p. 1050). The absence of clear-cut ethical rules is compounded by the fact that even the ethical guidelines for each specific discipline pay only limited notice to the exigencies of conjoint clinical work with couples.

We, along with others, have previously grappled with a number of important issues that emerge in couple therapy (e.g., Gottlieb, Lasser, & Simpson, 2008; Margolin, 1982, 1986, 1998; Margolin, Shapiro, & Miller, 2015; Snyder & Doss, 2005). Some of the topics (e.g., consent, confidentiality, boundaries) are common to any consideration of ethics in therapy but take on distinct characteristics in couple therapy. These topics bear reviewing because of their importance, and because, if ignored, they can quickly cascade into problematic situations compromising the therapist's ability to promote clinical progress. In addition, this chapter also addresses ethical considerations relevant to the new and changing landscape of couple therapy given the increasing prevalence of telehealth (American Psychological Association, 2013; Koocher, 2007), the availability of couple therapy in major health care facilities such as Veteran Administration (VA) Health Centers (Christensen & Glynn, 2019), couple treatments for individual mental and physical health problems (e.g., Baucom, Fischer, Corrie, Worrell, & Boeding, 2020; see also Chapters 24–28, in this volume), and growing access to online self-help couple therapy alternatives (see Chapter 30, "Telehealth and Digital Couple Interventions," in this volume, by Doss, Knopp, Wrape, & Morland). Furthermore, collective awareness has increased about the importance of considering that couple issues are inherently embedded in a larger sociocultural context, defined by a number of characteristics including race, ethnicity, sexual orientation, gender identity, and age (Kelly, 2017b; McGoldrick & Hardy, 2019; see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). The issues addressed in this chapter refer primarily to conjoint therapies when the goal is to help partners navigate acrimony and improve their relationship. Many of the issues, however, also are pertinent in conjoint therapies that focus more on the issues of one partner or that address issues of someone outside the therapy room (e.g., improving the parenting or the co-parenting relationship).

Though our focus throughout the chapter is on ethical issues, good ethical practice and good clinical practice are inherently intertwined. Effectively navigating ethical challenges requires awareness and anticipation of the ethical issues, and contemplating in advance how different decisions can lead to different pathways. This chapter thus aims to draw attention to ethical considerations that are quite common in couple therapy, that take on distinctive characteristics in couple therapy as contrasted with individual therapy, and that are fundamental to competence as a couple therapist.

CONSENT PROCESSES

Across disciplines, the first step in couple therapy—as in individual therapy—is conducting consent procedures to inform clients in understandable language about the nature of therapy (American Association for Marriage and Family Therapy, 2015; American Psychological Association, 2017a; National Association of Social Workers, 2017). Regardless of how consent standardly works in a clinical setting, and regardless of whether one partner already has consented to health care treatment more generally (e.g., as occurs in the VA system), starting couple therapy requires a new or additional consent process. We say "process" intentionally because, rather than just securing signatures on a form, consent comprises points that require face-to-face conversation. Beyond the discussion, consent requires documentation on a paper or electronic form with the signature of the therapist who has clearly stated the conditions of therapy, and with each partner's signature, as an independent agent. At times, conversation between the two partners, either with the therapist present or in private, is beneficial to sorting out their concerns.

As an example, the American Psychological Association Ethical Principles and Code of Conduct [Standard 10.01] lays out the following essential components to be addressed in consent to therapy:

> "(a) . . . psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality, and provide sufficient opportunity for the client/patient to ask questions and receive answers. . . . (b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. . . . (c) When a therapist is a trainee and the legal responsibility for treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedures, is informed that the therapist is in training and is being supervised

> and is given the name of the supervisor." (American Psychological Association, 2017a, p. 14)

Within these parameters, points that need additional clarification in couple therapy include the nature and goals of couple therapy, the potential risks, and confidentiality. In addition, for therapy involving couples or families, American Psychological Association (2017a, p. 14) Standard 10.02 states that therapists "take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person."

When couple therapy is conducted in a clinic that also provides individual therapy, the clinic's generic consent form may not provide sufficient information for couple therapy. In one of our university clinics, for example, consent procedures for couple therapy include an Addendum for Family and Couple Therapy as an accompaniment to the clinic's standard therapy consent form. Topics and example language from that Addendum appear in Table 31.1.

What Is Couple Therapy? What Are the Goals and Risks?

Psychotherapy is a mysterious process for many people, and couple therapy is even more unknown. As illustrated across the chapters of this *Handbook*, the specifics of what transpires in couple therapy vary by therapeutic approach. Some couple therapies are more structured and have more supporting evidence than others. Even within many couple therapy models, therapists are likely to tailor their treatments to meet the specific circumstances of each couple.

Still, in asking clients to consent to therapy, the therapist must describe, even in broad strokes, what a couple entering couple therapy might anticipate. What is the therapist's philosophy of relationship distress and relationship change, and how does that translate into the process and mechanics of therapy? Some specific details about therapy could include expectations about session frequency, length of sessions, and duration of therapy. Other points that likely are relevant to a couple consenting to therapy might include key questions:

What does the assessment entail and will they receive feedback from that assessment?
Will individual sessions be part of the process?
Will therapy include learning new skills, experiencing new ways of communicating in the session, engaging in activities between sessions?

Clients who have had prior individual therapy may be more comfortable with therapy overall but also may be particularly prone to enter couple therapy with misconceptions regarding the therapeutic relationship, confidential policies, and goals in a dyadic context.

In addition to therapists using the consent process to begin to orient clients to couple therapy, ethical guidelines require presentation of potential risks. Certain therapeutic models emphasize the importance of using the intake session to build positive expectations about couple therapy. This goal, however, needs to be tempered with the message that therapy can be an uncomfortable process with uneven progress. Certain sessions may be difficult, and partners might not feel better each time they leave the therapy session. More importantly, although couple therapy overall has good rates of success (e.g., Bradbury & Bodenmann, 2020; Roddy, Walsh, Rothman, Hatch, & Doss, 2020; see also Chapter 1 on theory and practice of couple therapy, in this volume, by Lebow & Snyder), it does not lead to relationship improvement for all couples. Moreover, some clients in couple therapy will learn things about themselves, their partner, or the relationship that will lead to the conclusion that separation or divorce is a better pathway. This outcome, though sometimes unanticipated and often tremendously disorienting and disruptive, does not necessarily imply that couple therapy has failed, as this may be a reasoned and reasonable result under some circumstances.

What Is the Nature of the Therapeutic Relationship? Who Is the Client?

Clarifying who is the client in couple therapy is one of the clearer examples in which ethical and clinical issues are inextricably linked. The obvious challenge in couple therapy is balancing the commitment to the well-being of both partners, especially when the goals of partners are at odds. In couple therapy, benefiting both partners generally means developing case conceptualizations that take into account each partner's role in the relationship problems and impartially understanding each one's goals, perspectives, hurts, and frustrations. Benefiting both partners also means that they have equal status as clients (Lebow, 2019), an idea that may not be obvious in certain settings (e.g., at the VA, where couple therapy is part of the health care of the

TABLE 31.1. Sample Consent Form Addendum for Couple Therapy

Topic	Example language
What is couple therapy? What are the goals and risks?	• With the focus on the couple, goals can include exploring relationship patterns and expectations, improving communications, examining what each person contributes to the relationship, resolving conflicts, learning new interaction patterns, accepting differences between partners, and dealing as a couple with individual changes, outside adversities, and other important people in the couple's life. • Risks of couple therapy could include discovering something unpleasant or painful about the relationship or coming to a decision to separate or end the relationship.
Who is the client?	• For couple therapy, the couple as a whole is considered the client. While there may be a specific focus on a particular member of the family, for purposes of confidentiality and record keeping the family is the client.
Whose goals are addressed?	• There may be conflicting goals to be addressed among the partners. The objective of therapy is for everyone's goals to be addressed. Differences between each member's goals will be discussed during therapy.
How is private information handled?	• Any information shared by any member of the couple may be brought up in future sessions, and we cannot guarantee that information shared with the therapist by one of you will be kept confidential from the other(s). • Any record keeping for couple therapy is kept in a single file. Because the file may contain information about multiple adults, written permission from all adults capable of providing consent who are part of the couple therapy is necessary to release information to any party. • The only exceptions to this policy occur in those circumstances outlined in the general consent—when we are required by law or ethical code to break confidentiality (e.g., any member is a danger to self or others, evidence of child abuse/neglect).
Can the information from therapy be used in disputes between the partners?	• You should understand that services provided to couples and families, and the information included in your clinic record, are not suitable for child custody or divorce proceedings that you may be pursuing now or in the future. Psychological assessments and reports for child custody and divorce proceedings are forensic services that require specialized training.

Note. Adapted with permission from the University of Southern California Psychology Services Center Addendum for Couple and Family Therapy.

servicemember). Moreover, within the dynamics of a given couple, one or both partners may dismiss the validity of their own feelings and not advocate for themselves (Wile, 2013), especially if the couple presents with an agreed-upon perspective that one is more at fault and needs to change more. Working with such couples may require the therapist to set the tone of equality by helping both partners identify their own goals and acknowledge their importance in influencing relationship processes and outcomes.

Many couple therapists label the relationship per se as the primary client, with the overriding goal of improving the relationship. With this framework, the separate perspectives and even some disparate goals of the two clients are reformulated into couple patterns. Systemic case conceptualizations built on assumptions that both partners contribute to the couple problems and that couple patterns mutually sustain the problems help foster this stance as "relationship advocate." Targeting change at the relationship level works well if both individuals are committed to the relationship and both will benefit from relationship gains. In these situations, however, the couple therapist may experience a tension between working to improve the relationship and benefiting each of the two partners. As described in the section on contraindications for couple therapy, in certain situations, advocacy for the relationship must be tempered with consideration for the emotional and physical well-being of each partner. In these situations, the therapist must consider the risks to remaining in the relationship and whether those risks can be mitigated through therapy. Promoting relationship improvement when one partner has very low commitment to the relationship, for example, is likely to be countertherapeutic, possibly increasing the hope and emotional investment of the more committed partner, and ultimately resulting in greater disappointment and sense of failure (Margolin, 1982; see also Chapter 21 on divorce, in this volume, by Lebow). On the other hand, short-term conjoint therapy for "mixed-agenda" couples (one contemplating separation and the other wanting to preserve the relationship) can be done ethically if the stated objective is to figure out the direction of their relationship—not to promote emotional connection or relationship improvement (Doherty, Harris, & Wilde, 2016). With any conjoint work, however, we need to be forthcoming with clients that one partner's decisions—whether to start couple therapy or perhaps as a consequence of something learned in therapy—may not be the outcome the other partner desires (Koocher, 2007).

Moreover, maintaining therapeutic balance between partners is more an aspirational goal than a moment-to-moment reality. During any one session, a therapist may have good reasons to focus more on one or the other partner's concerns or reactions, especially if change, acceptance, or greater understanding by that one person benefits the couple. Therapists can ease the discomfort of these short-term imbalances by acknowledging when the one-sidedness has occurred or anticipating in advance that it is likely to occur. Therapists can also ask in advance for permission for partiality toward one partner at a given point in therapy or request the clients' feedback if they feel that therapy has become disproportionately focused on one partner's perspective.

Still, therapists themselves need to be self-aware if they consistently feel less empathic to one partner than to the other. Such leanings can emerge when the therapist finds one partner personally more challenging to work with or more responsible for the relationship problems. In addition, a notable feature of couple therapy is that the concerns described are quite commonplace and may be reminiscent of what therapists themselves have personally experienced. Partners' frustrations, accusations, and longings may strike familiar chords and elicit shocks of recognition of times when we ourselves have fallen short in significant relationships. Moreover, the issues with which couples are struggling, for example, conflict over moving to a new city for one partner's job, the timing of when to start a family, whether to get divorced, or being at different ends of the political spectrum, may resonate with the therapist's own experience. In such situations, the therapist might inadvertently align with one partner, or may feel a greater sense of hopelessness or hopefulness based on personal circumstances. Recognition of an imbalance in empathy, whatever the reason, should serve as a trigger for the therapist to work harder or differently to better empathize with the other partner. Sharing the same gender, race, or ethnicity with one but not the other partner also can create a perceived or real imbalance in identification with the two partners. The therapist might seek outside consultation for guidance and, in cases where the imbalance continues to compromise the therapist's effectiveness, might consider referring the couple elsewhere.

Confidentiality and Private Information

Confidentiality may be the most vexing issue in couple therapy. The fundamental dilemma is whether the therapist does or does not become the holder of private information from the individual partners. Though the conjoint setting of the time in couple therapy leaves little opportunity for individual confidences, the client who wants to reveal something privately to a therapist always can find a way to do so—when the partner steps out momentarily or through a private e-mail, text, or phone call—or in preplanned individual sessions. Thus, the question is not whether private information will be shared between a partner and the therapist but rather how the therapist handles that information.

Affairs are a familiar example of secrets that can come up in couple therapy. Relationship infidelity can take many different forms: ongoing or past, with and without emotional intimacy, with or without sexual intercourse, with one or multiple partners, in-person or Internet relationship, and in couples with or without a commitment to monogamy. Partners may have different ideas about what it means to be unfaithful in the relationship. For example, they may disagree about whether an intense, emotionally close, platonic relationship is just as threatening as a short-lived sexual encounter. The therapist and the couple also bring their own personal values about what type of involvement with other people becomes a compromising factor to the couple. Beyond affairs, partners may reveal other types of private and potentially devastating information to the therapist that can have far-reaching implications for the couple, the uninformed partner, and the course of therapy (e.g., squandering the family savings through risky investments or gambling, addictive behaviors, personal traumatic experiences, prior criminal record, and secrets involving other family members). In addition to embarrassment and shame, such information is often withheld in a relationship to avoid hurting the partner and to prevent significantly altering the relationship in a way that cannot be undone.

Therapeutically, eliciting private and previously undisclosed information can be part of a healing process for an individual who may be burdened by the secret, and can determine whether and how therapy might proceed. In certain situations, secrets first disclosed to the therapist, then disclosed to the partner in a conjoint session, can facilitate couple therapeutic progress, especially when keeping a secret has undermined the emotional intimacy between partners (e.g., learning about a partner's previously undisclosed sexual abuse can be beneficial in explaining and overcoming certain entrenched relationship patterns in the couple). Conversely, however, bringing other disclosures to the couple session can precipitate a crisis, particularly when those disclosures violate a fundamental relationship assumption, such as the shared understanding that neither partner will have emotionally or sexually intimate relationships outside the relationship. Considerable relationship disruption and instability can accompany the disclosure of such violations. Ultimately, however, such disclosures may not be irredeemably harmful to the relationship and may, in fact, motivate couples to confront other underlying issues in their relationship. Data from a 5-year posttherapy follow-up, for example, show that couples who disclose infidelities in the course of couple therapy have fewer divorces than couples who do not disclose them (Marin, Christensen, & Atkins, 2014).

Two general approaches to confidentiality both have merit as long as both partners are fully aware of the policy and the therapist consistently applies the policy across partners. To make sure partners fully understand the key points surrounding confidentiality, these need to be stated in simple terms in the consent form and also said aloud. In one approach, the therapist offers no guarantee that information shared with the therapist will be kept confidential from the other partner and justifies this position with the explanation that secrets undermine the goals of improving the relationship (Lebow, 2019; Margolin, 1982; Margolin et al., 2015). The therapist informs the couple verbally and in writing during the consent process that any information that one partner shares with the therapist *could be shared* with the partner in a later conjoint session. The therapist also may remind the client of this policy prior to an individual session or when sensing that one of the partners is about to disclose a secret. Knowing that private information could be brought into the couple session, the partner who shares closely held secrets often is looking for a way to disclose such information to the partner; that is, clients sometimes want to unburden themselves of carefully guarded secrets but do not know how and are understandably concerned about the negative consequences of disclosure. The advantage to this approach is that the therapist avoids situations of holding on to information from one partner that could be highly important to the well-being of the second partner. Yet the downside is that clients may be less likely to divulge such information.

Alternatively, in a second approach, the default is that information can be shared, but partners have the option to explicitly inform the therapist if there is something they want to keep confidential (Christensen, Doss, & Jacobson, 2020). Therapists taking this approach, compared to the prior approach, are seemingly more likely to learn sensitive, private information. Having received such information, therapists can encourage a thoughtful discussion about the relevance of the information for couple therapy and for the well-being of the partner. A disadvantage of this approach, however, is that the therapist may get boxed into a predicament in which the disclosing partner refuses to share the information with the other partner.

Although the "ground rules" for these approaches are different, they converge around some crucial points. First, with each of these approaches, the therapist is not obligated to share everything. That is to say, not all secrets need to be divulged. Second, and relatedly, with each of these approaches, the therapist may end up wielding significant influence in determining what needs to be shared and trying to encourage a partner to disclose information. The calculus about how strongly to encourage a disclosure typically is predicated on an evaluation of the relevance of the information to the current therapy, as well as to the well-being of the uninformed partner. Therapists commonly struggle, for example, with the question of whether a past affair needs to be disclosed. The answer still may not be clear even with careful consideration of multiple issues, including the importance of the external relationship, the extent to which the partner suspected the affair and was made to feel "crazy" for voicing such suspicions, and the extent to which the affair was part of a pattern of behavior. In addition, the question of whether the affair might cause health risks in the form of sexually transmitted diseases for the non-affair-involved partner warrants careful consideration. Disclosure of a prior affair has the potential to turn multiple lives upside-down, first and foremost, the primary relationship, where the disclosure may shatter the non-affair-involved partner's assumptions about the affair-involved partner's feelings toward them and about the relationship as a whole. Affairs also can take a toll on relationships with children and with other family members. Disclosure of an affair furthermore has implications for the life of the other member of the outside relationship (e.g., if the non-affair-involved partner informs a non-suspecting spouse of the affair). Even with a *prior* affair, weighing these various risks against the long-range psychological and medical risks to the non-affair-involved partner is extremely complicated, warrants the utmost care, and is a weighty responsibility for the therapist.

Both approaches to confidentiality, however, are put to an even more challenging test when the therapist learns about an undisclosed *ongoing* affair—again, an undeniably uncomfortable situation in which the therapist's responsibility to the welfare of both partners must be carefully weighed and immediate decision making may be required. Ongoing affairs are unique from other secrets because many couple therapists will not work with a couple when one partner concurrently is sexually or emotionally involved with someone else. The rationale for this policy is both pragmatic (therapy will not succeed) and ethical (it is unfair to the unknowing partner). Knowing this policy, unfaithful partners who choose to divulge an outside relationship to a couple therapist are making a choice about ending the affair or not continuing in couple therapy. Those who decide to divulge an outside relationship may themselves be struggling with the situation and may understand how their divided attention makes couple therapy untenable.

However, if the participating partner agrees to end the extradyadic relationship, how does the therapist know that indeed has occurred? How much and what type of follow-up should be done? And does the affair need to be disclosed to the partner for therapy to continue? Alternatively, if the affair is not ended and couple therapy thus needs to be discontinued, how does that happen without abandoning the uninformed partner? Usually, the onus for ending the couple therapy is ambiguously attributed to the partner with the outside relationship. Ethical policies about maintaining individual confidences need to be in line with the therapist's therapeutic approach about whether it is acceptable to remain silent about a disclosed affair, whether to encourage the affair-involved partner to share that information, and what the therapist will do if the affair-involved partner is not willing to disclose. While policies about confidentiality provide general guidelines about whether the therapist can disclose information deemed important to share, the specific circumstances of any one couple still demand painstaking decision making.

In addition to the impact on the couple relationship, a potential risk to learning a secret from one partner is that it can fundamentally change the dynamics of the therapeutic alliances. The therapist risks being drawn into a special alliance with one partner that excludes the other partner, thus compromising the therapist's ethical responsibility to serve that second partner's best interests. If the other partner discovers the secret, they may feel doubly betrayed—by the therapist as well as the partner. Doherty (1995) reveals the risk of holding one partner's secret in a case in which the husband had a serious medical condition that he had been minimizing and lying about to his wife. Despite the husband's initial promises that he would eventually tell his wife about the condition, Doherty came to the realization that the husband had no plans to disclose the medical information—which, although not central to the presenting concerns of the couple, would indeed be a crucial factor to the wife's sense of security in the relationship. Doherty poignantly described finding himself in a situation where his "hands were tied in the marital therapy because [he] knew a secret the wife did not know. . . . [The husband] wielded a form of informational power over her and [he, as the therapist] collaborated" (p. 80).

Importantly, policies about confidentiality and how they are implemented are an essential element of trust—partners' trust of the therapist and partners' trust of one another. Clarity, consistency, and transparency regarding confidentiality are key to the clients' trust of the therapist; clients need to have faith that the therapist is applying the stated guidelines in a caring and impartial manner that reflects the therapist's commitment to the well-being of both partners, and that follows logically from an overriding therapeutic goal of working on the relationship. Therapists' explicit discussion of how confidentiality policies intersect with the goals of therapy (and who the therapist is responsible to) can also foster that trust.

Confidentiality policies also intersect directly with lack of trust between the partners, which is a common and particularly challenging therapeutic issue in couple therapy. Therapists themselves have different values about the importance of honesty between the partners (Doherty, 1995), and this view might be reflected in the therapist's willingness to be the holder of individual confidences. It is generally recognized, however, that the initial damage of a relationship violation is only compounded when the partner continues to deny and lie about the violation. Attempts to squelch a partner's correct suspicions—through denial or gaslighting (i.e., getting the distrustful partner to question their own perceptions of reality)—typically make a situation far worse than admitting the violation. Though such issues regarding trust present couple therapists with some of their greatest challenges, the pathway is somewhat more straightforward with clear confidentiality policies that are communicated before any issues surrounding private communications and trust emerge in therapy.

Flow of Information Outside the Therapy Room

Joint Records and Privilege

Confidentiality discussions in couple therapy also need to address how both the clients and the therapist handle the flow of private information outside of the therapy room. For the therapist, key issues include documentation and record keeping, and the release of records for legal purposes. Both therapist and couple need to be clear on who has access to therapy records. Psychotherapist–patient privilege gives the patient decision-making rights as to whether treatment information, as documented in the record, is or is not disclosed in court proceedings. Stated plainly, clients, as the legal holders of privilege, have the right to request release of information from their therapy file to be entered as evidence in a court proceeding, such as a divorce or child custody case. But what if there is a one joint file for the couple? In the United States, the specifics of psychotherapist–patient privilege are found in state laws, which vary from state to state and do not always provide clear guidance for circumstances in which therapy involves two or more patients (American Psychological Association Practice Organization, 2014); patient privilege also varies across jurisdictions in other countries. In couple therapy, ambiguity may exist about who holds the privilege if there is one joint record. Usually, the release of a joint file, which also may include information from individual sessions, requires written consent by both partners and specification about what exactly is to be released—the entire file or a summary. However, with different jurisdictions having separate rules about whether one partner can request or subpoena a copy of the file without the second partner's legal waiver (Margolin, 1982, 1998), the therapist is advised to seek up-to-date legal counsel before releasing the file.

In some managed care settings, the records of couple sessions may be combined with the general health record of one or both partners, a point that needs to be mentioned in consent. In the VA system, for example, couple therapy records are part of the health chart of the servicemember, since care is accessed through that person's connection with the VA. Practically, this means that therapy notes, including information from individual sessions with each partner, are available to the servicemember and to other VA health care providers but are not available to the non-servicemember spouse. Alternatively, therapists in a VA could generate a collateral chart for the nonveteran spouse that only the spouse could access. Other organizations may do regular audits of files or access files for billing and insurance. Consent procedures need to spell out clients' rights to access their therapy file and also specify the systemic limits on confidentiality.

Partners' Handling of Session Information

Couples themselves also play a key role in managing the flow of information. Some partners want to discuss their therapy with trusted individuals in their lives, such as family members or friends, whereas other partners view being in therapy as highly personal information and may experience shame or embarrassment at being in couple therapy. For example, in one case we saw, a client's brother-in-law asked our client about his experience in couple therapy, and that was the first the client knew that his wife had told her sister about couple therapy. The sister had told her husband and perhaps other family members. The male client, who saw therapy as a private matter, felt utterly betrayed by his wife and sister-in-law, and was unwilling to attend any family functions. Already sensing some judgment by his wife's family, he now was mortified that the family knew that he was in therapy, and that he and his wife were having marital problems; he also presumed that he was being portrayed negatively to the family. The wife's explanation that she was simply seeking support from her sister did little to mollify him. Setting boundaries from the start of therapy regarding whom the couple can share information with regarding their therapy is an important part of clarifying confidentiality. In situations with infidelity, an important decision is whether to share information about the affair. The injured partner may want to share that information to retaliate or simply to elicit support from others, whereas the partner in the extradyadic relationship may want discretion. Whether the information is shared with the couple's children is particularly consequential in light of the potential impact on both parent–child relationships. Some couples come to relatively easy agreements about whether to share information from the therapy sessions or about their relationship more generally; for other couples, disagreements about the decision to share such information may be a source of significant conflict.

TRANSITIONS TO AND FROM COUPLE THERAPY

Confidentiality before Therapy Formally Begins

Despite following good clinical practice and discussing confidentiality as soon as therapy begins, issues regarding the handling of private information may arise prior to any consent procedures. How couples enter therapy and where they are being seen influence what ethical dilemmas might emerge. When clinics and therapists specialize in couple therapy, the entire intake procedure may be aimed at having both partners start in therapy simultaneously and on an equal footing in terms of understanding the therapy process and establishing a relationship with the therapist. Even then, however, one partner is likely making the initial request for therapy and is communicating with a receptionist or directly with a therapist, or may be replying to a "Contact me" text box on a website. With any of these options, the information provided reflects that one partner's perspective about the reasons for seeking therapy. Likewise, with any of these options, the therapist needs to be prepared to receive information that enlists the therapist's sympathies (e.g., "I caught my husband texting another woman") or has yet to be shared with the partner (e.g., "I made a terrible mistake by sleeping with my coworker and now I really want to improve my marriage"). Couple therapists should be prepared, even at this early stage, with a clear policy about whether information gleaned during the intake contact is confidential and should structure the intake accordingly.

Transitioning from Individual to Couple Therapy

Beyond those clients who seek couple therapy as a stand-alone intervention, other scenarios for entering couple therapy are quite common and can pose additional ethical complications. With relationship problems frequently raised as a topic in individual therapy, addressing those problems conjointly can be a reasonable approach. Shifting from individual to couple therapy, however, requires considerable forethought on how to best serve the needs of two clients in light of the imbalance in the therapeutic alliance with the two partners and preformed impressions that have been filtered through the original client's point of view.

Despite the care required in making such transitions, the shift from individual to couple therapy potentially leads to very effective outcomes, particularly when it becomes clear that relationship dynamics are maintaining or impeding progress in the treatment of the individual client. When a second partner is brought in, distinguishing whether that person is to be included for couple therapy or is a collateral contact (i.e., only to assist in the treatment of the primary patient; Knapp, Younggren, VandeCreek, Harris, & Martin, 2013) is important. For example, in some cases, the inclusion of the second partner is limited in scope and perhaps for a short duration (e.g., partner-assisted approaches; Baucom, Kirby, & Kelly, 2009) in which one partner presents with a psychological or medical disorder and the other partner is brought in for conjoint psychoeducation about the disorder and for implementing relationship changes that result from the disorder or that affect the intervention for the disorder. For these situations of collateral involvement, special collateral consent forms may be most appropriate, clarifying that the therapist's primary responsibility is to the client already being seen, and that the collateral participant has no legal rights in therapist–patient privilege or access to charts. Alternatively, an increasing number of disorder-specific conjoint therapies are available, in which the couple works as a team against the disorder, for example, in interventions aimed toward "communal coping when partners view a stressful health problem as 'ours' rather than yours or mine" (Rohrbaugh, 2021, p. 18; see also Chapters 24–28, in this volume). With either of these approaches, the partner with an identified mental or physical health problem may have been in therapy prior to conjoint therapy. Transitions from individual to couple therapy also occur in situations not involving a specific individual disorder, such as when one partner is in therapy to discuss a life transition and it becomes obvious that the transition has implications for the other partner, or when one partner is receiving therapy for parenting and the discussion of parenting concerns exposes couple issues.

With such transitions, an important consideration is whether the therapist who had been seeing the individual should also be the therapist to see the couple, assuming that the therapist has expertise in couple therapy. An important key is clarity and transparency with both partners regarding both treatment goals and whether the therapist maintains a special alliance with one partner or moves to a position where the couple is the unit of intervention. Is the partner who has been in individual therapy comfortable with the therapist now functioning on behalf of both partners? Is the newcomer to therapy comfortable entering a situation where the partner has an ongoing relationship with the therapist and has already shared details about the couple relationship? Equally relevant, what is the therapist's personal assessment of their own capacity for establishing a working alliance and serving the best interests of each partner? The wellspring of knowledge from working with one partner can be an asset in terms of an efficient start to couple therapy. It also can be a liability, however, if biases exist toward one or the other partner or if the therapist too quickly formulates a case conceptualization based primarily on information from one partner. Frank discussion of these potential advantages and liabilities with both partners is needed on an ongoing basis, not just when couple therapy starts.

Commingling Couple and Individual Therapy

At times, couple therapy and individual sessions occur alongside each other—for short or long periods of time—or couple therapy transitions to individual therapy for one or both partners. Individual sessions are often held as part of couple therapy, particularly during the assessment phase or sometimes for brief periods in couple therapy for issues of safety planning or to help partners organize their thoughts for difficult couple conversations. Individual sessions are sometimes useful, for example, in helping each partner sort out jumbled feelings and thoughts around emotionally intense situations as preparation for confiding in one another. That situation of conducting sporadic individual sessions in the service of the couple therapy is quite different, however, from transitioning to a phase of therapy in which the therapist is working separately with one or both partners for an undetermined period of time. Despite the temptation at times to transition to individual sessions when the couple dynamics are overwhelming and highly contentious, managing separate sessions with both partners poses clear challenges with respect to managing information, confidentiality, and balancing alliances. Moreover, there is no evidence, to our knowledge, that couple goals are best addressed through extended individual therapy simultaneously with both partners.

On the positive side, as couple therapy winds down, one partner may request individual sessions to work on an issue outside the scope of the couple therapy. Again, this can be an efficient and effective transition given the established therapeutic relationship and considerable knowledge about the relational context of the individual issue. In deciding whether the couple therapist should provide individual therapy, we recommend addressing the possibility of whether couple therapy will likely resume, and whether that would be compromised or precluded altogether by individual work with one partner. Any transition to individual therapy would require explicitly redefining or renegotiating expectations regarding confidentiality and therapeutic goals, and whether the possibility for resuming conjoint work at either partner's request still is an option.

Commingling Couple and Family Therapy

Couple therapists who take systemic perspectives are well aware of the interconnectedness among the couple relationship, the parent–child relationships, and the co-parenting relationship (Grych & Fincham, 2001). The impacts of the couple relationship on children are well documented. Overt conflict between partners is recognized as particularly threatening for children; relatedly, threats to a child's security, such as when the family unit is at risk of dissolving, also impact children (Davies & Cummings, 1994). Even when parents maintain that children have not heard their arguments (e.g., "They were asleep"), children often can provide accurate and detailed accounts of what transpired (Jaffe, Wolfe, & Wilson, 1990). Children who come to believe that they are somehow responsible for the parents' conflict, or attempt to intervene to stop the conflict are at particular risk for harm.

Does the couple therapist have an ethical obligation to inquire about the well-being of children when treating their parents? Though here the child is not the patient of the couple therapist, the couple therapist might be in the best position to understand how the child might be impacted by the couple relationship—especially since children typically are not in a position to raise concerns or seek therapy on their own. Considering the child's well-being and perhaps even shifting the focus of therapy to parent–child relationship issues may be beyond the initially agreed-upon scope of the couple sessions. In our view, however, this may be an important new direction and potentially one that is consistent with both partners' values. Making such a shift may involve expanding or revising the goals of therapy. If the child is brought in for a session (e.g., either individually or conjointly with the parents), the conditions of therapy, including confidentiality and privacy considerations between the parents and child, should be discussed.

Likewise, there may be reasons to bring in other individuals whose lives intersect with and affect the couple, especially if doing so aligns with the overriding goals of the couple. When working with stepfamily couples, for example, occasions can arise when it would be useful to involve the former spouse of one partner or the other to address childrearing concerns (see also Chapter 22, "Therapy with Stepfamily Couples," in this volume, by Papernow). Even though such relationships can be fraught with complexities, there can be value to having everyone attend a therapy session in which communications can be clarified with all present. Similarly, inviting other family members to a session can be beneficial to how the couple jointly copes with evolving circumstances in their family or social network. For example, for a couple seeking guidance in discussing their role with one of their parents who is newly widowed, the therapist can initially work with the couple to help them arrive at jointly agreed-upon perspectives. A further step could then entail having a discussion with the parent in a session and with the therapist's assistance. In such situations, the collateral nature of that family member's involvement needs to be carefully explained. If that collateral member wants further therapy, a referral likely would be in order, as working with multiple members of an extended family can be quite complicated. On the other hand, working with separate units of an extended family is not always improper, and the decision regarding whether to do so may depend on other available therapeutic resources in the community.

DANGEROUSNESS AND EXCEPTIONS TO CONFIDENTIALITY

Regardless of confidentiality policies, mandated reporting requires therapists to report certain information that bears directly on the well-being and safety of one of the partners or another identifiable person. Mandated reporting of elderly adult abuse and child abuse are two such exceptions to confidentiality to be specified in the consent procedures. Protecting a child or elderly adult may mean breaching confidentiality between the partners, disclosing information to mandated authorities, and possibly disclosing information about people outside of the therapy setting (e.g., abuse by another family member). Whether child or elderly adult abuse is hinted at or brought up directly, the therapist is responsible for further assessing in a timely fashion whether someone is at risk. As in individual or family therapy, the reporting of abuse in couple therapy can potentiate a breach in therapeutic alliance. The unique situation in couple therapy, however, arises when one partner raises concerns about the other partner's abusive behavior. When concerns about abuse surface during a conjoint session, the partner being blamed might become defensive or dismissive. However, bringing forth such concerns to be discussed with the therapist's guidance can be viewed as a positive step toward whatever next steps are needed (e.g., dealing with one's own or the partner's abusive behavior toward a child). Alternatively, if one partner discloses the other partner's harsh and potentially abusive behavior toward their child in an individual session, it typically is best to bring that back to conjoint session—unless that disclosure puts the disclosing partner or the child at greater risk. Although the reporting of abuse can have serious implications for future work in couple therapy, particularly if the partner named in the report feels betrayed, the couple therapist can still strive to provide support to the couple through the investigative process and thereafter. The overriding goal of making sure that a child or elderly adult is not at risk of further harm or neglect is the guiding principle and, in the case of child abuse, may prompt the parent to enroll in additional services to improve their parenting. Also, because reporting laws vary by state and sometimes by county within a state, being aware of what would prompt a report is critically important.

Confidentiality considerations around domestic violence are even more complicated, and therapists need to be knowledgeable about reporting laws in their state. In California, for example, domestic violence is a crime, but, unlike child and elderly adult abuse, therapists are not mandated to report assault against a partner. In fact, in the state of California, a therapist who hears about domestic violence from the victim or sees direct evidence of battering through bruising still needs written authorization from the victim to release confidential information. The Tarasoff rule (i.e., that if a patient presents a serious danger of violence to another person, the therapist is to use reasonable care to protect the intended victim against such danger) is applicable only when the batterer communicates a serious and credible threat of physical violence to a partner (Weinstock, Bonnici, Seroussi, & Leong, 2014). A 2004 extension of the Tarasoff rule also expands the duty to protect if a family member of the batterer informs the therapist of a serious threat of physical harm posed by the batterer. It is important to note, however, that there is considerable variability in how the Tarasoff rule is applied across states. Some states have a duty to warn, whereas others have a duty to protect the victim. Some states impose a mandatory duty, whereas other have a permissive duty, such that providers are not liable for breaching confidentiality (Adi & Mathbout, 2018). Certain states have a higher bar than others for breaching the client's privacy.

Domestic violence also may raise questions about risks to children, with states varying as to whether domestic violence is considered a form a child abuse. Exposure to domestic violence is a risk to children's physical and emotional safety to be assessed. Particular points to consider include whether the child has intervened in the domestic violence; has been injured when intervening or witnessing the domestic violence; or is showing emotional, psychological, or physical effects related to the domestic violence (Bragg, 2003).

Dangerousness and the potential for harm also emerge in other ways that may fall outside thresholds for mandated reporting but still pose notable risks, and highlight issues if confidentiality has been promised. One example is a partner's extrarelationship sexual encounters that put the unknowing partner at risk for HIV infection (once but no longer considered a potential Tarasoff trigger) and other sexually transmitted diseases (STDs). Another example is arguments that get out of control through physical aggression (e.g., one push landed the wife on floor). Partners themselves may downplay the dangerousness of the events (e.g., "The affair is over and no one had any symptoms of STDs"; "She only landed on the floor because she lost her balance"). In such instances, the therapist may be more concerned about clients' safety than they themselves are. Confidentiality parameters established at the start of therapy during consent can greatly influence the therapist's available course of action.

CONTRAINDICATIONS FOR COUPLE THERAPY

Although therapists might subscribe to the philosophy that little downside exists to giving couple therapy a good effort—if that is what the couple requests—several situations in couple therapy may bring up questions about "beneficence" (promoting the welfare of others) and "nonmaleficence" (doing no harm). To be clear, these situations do not lead to an immediate curtailing of any conjoint work with the couple. They do, however, require pausing typical couple therapy goals until the therapist determines whether each partner's safety and well-being can be established as a priority.

As previously described, most couple therapists agree that when one partner is involved in an outside relationship, couple therapy should not go forward unless that partner is willing to end that relationship and focus on improving the primary relationship. Couple therapists differ, however, in what approach they take if the affair-involved partner is ambivalent about ending the outside relationship. Some therapists remain therapeutically engaged with the couple for a finite period of time as a guiding resource to help the affair-involved partner work through this important, complicated decision (Baucom, Snyder, & Gordon, 2009; see also Chapter 18 on infidelity, in this volume, by Gordon, Mitchell, Baucom, & Snyder). Still, a significant dimension of this ethical dilemma is ultimately knowing whether the outside relationship has indeed ended. Moreover, options for working through the decision with an ambivalent partner and for determining whether therapy can proceed are notably more limited when the non-affair-partner is unaware of the outside relationship. In either case, couple therapy with the goal of relationship improvement is contraindicated if one partner is committed exclusively to the primary relationship, while the other partner's attention and affection are divided and directed elsewhere.

Relationship violence poses another key ethical risk for engaging in couple therapy. When directly assessed, between 25 and 75% of treatment-seeking couples report having experienced relationship aggression, albeit of varying degrees of severity (Simpson, Doss, Wheeler, & Christensen, 2007). Based on these numbers, couple therapists have an ethical responsibility to assess for relationship violence, which couples are unlikely to spontaneously report unless asked about specific acts of aggression (O'Leary, Vivian, & Malone, 1992). Whereas some clinicians categorically rule out couple therapy in the case of aggression and violence, others call for a more nuanced approach in which couple therapy may still be possible. The clinician must conduct a thorough and careful assessment of the level of violence and risk of harm, knowing that safety concerns may make obtaining good information difficult due to fear on the part of a victimized spouse. Conceptually, the treatment of violence in a conjoint setting may be useful due to the ability of the clinician to observe problematic dyadic communication patterns that can escalate into verbal or physical aggression (see also Chapter 17 on partner aggression, in this volume, by Epstein, LaTaillade, & Werlinich). However, an approach that identifies both partners' roles in a dyadic process and avoids assigning individual responsibility for aggression perpetration runs the risk of blaming a victim for the partner's abusiveness. In deciding whether couple therapy is ethical, the clinician must carefully assess the emotional and physical dangerousness of the violence, the dynamics and impact of the abuse, and the risk that the victim who discloses abuse in the therapy session might later suffer retaliation at home. Accordingly, lower-level mutual violence may lead to a different decision than violence in which one partner is abusive and domineering of the other. Couple therapy should only take place if violence is not ongoing and the aggressor takes responsibility for the violence (Johnson & Lebow, 2000). As in all treatment settings, regardless of whether couple therapy proceeds, the clinician must attend to acute safety concerns with safety planning for the partners, and be guided by a principle of not causing harm to the clients.

Beyond couples presenting with physical violence, couples who persist in behaving destructively toward one another pose an additional ethical challenge to the couple therapist (Wolksa, 2011). Couples who persist in patterns of behavior that further erode the relationship (e.g., emotionally abusive, contemptuous, or disparaging behavior on the part of one or both spouses), with an apparent inability or unwillingness to acknowledge responsibility for or reduce such behavior over several sessions, may be unlikely to improve. Furthermore, the couple may be ill-served because ongoing therapy could communicate that the therapist tacitly endorses the relationship or the behavior, and also endorses the possibility that the relationship will improve.

On the one hand, the therapist has the goal of providing benefit to the couple, and that may take time. On the other hand, to the extent that a couple stagnates and uses the therapy time to engage in destructive behavior, therapy may be harmful, and especially so if the behaviors continue unabated under the presumptively "helpful" guidance of a therapist. Whereas the therapist's job is not to dictate whether the clients should stay in a relationship, the therapist does have to make the decision regarding whether to endorse the relationship and destructive behavior by engaging in couple therapy.

Different situations and theoretical orientations would prescribe different approaches to this ethical dilemma. In some cases, for example, when the couple values maintaining the relationship even if it is less than ideal, regular or periodic sessions may keep a relationship on an even keel and help the couple withstand intermittent crises. For other couples, staying in the same household may be detrimental to one or both partners and perhaps to children in the household. Repeated assessments of therapeutic progress at regular intervals with possible redefinition of therapy goals can be helpful in making these determinations. Out of respect to the couple's autonomy, sharing the dilemma with the couple and being direct about putative harmful impacts of behavior in the relationship may be warranted and may even open up productive discussions about future directions.

Likewise, in cases in which one or both partners want to end the relationship, couple therapy may be harmful or futile (see Chapter 21 on divorce, in this volume, by Lebow). Particularly if the desire to end the relationship is not mutual, working conjointly can send a misleading message (i.e., that there is still hope) to the partner wanting to save the relationship. That said, most partners seeking couple therapy have entertained some ideas, whether exhaustive or vague, about ending the relationship. Thus, for many, normalizing such ideas and making an agreement to postpone such decisions while working to improve the relationship is a reasonable strategy. Alternatively, however, when one partner has a clear intent to leave the relationship, helping the couple to separate as well as possible may be a viable goal, again, with a consideration of what parties might be affected by the separation. Revenge toward the partner that draws in the children (e.g., limiting the partner's contact with children or denigrating the partner to the children) needs to be directly addressed by the couple therapist. Relatedly, for couples with children, establishing clear parameters is important, for example, whether the therapist only provides treatment versus becoming involved in custody recommendations as a source of information for a custody evaluator (American Psychological Association, 2010; Knapp et al., 2013). Although couple therapists might meet with divorcing couples with the clearly stated, focused goal of reducing acrimonious conflict, recognition that couple therapy is being sought to aid in a custody battle is a clear counterindication for couple therapy as ordinarily practiced. More generally, combining clinical and forensic roles is conflictual and risks harm to the clients, and is a liability for the therapist (Greenberg & Shuman, 1997).

Couples in which one or both partners present with significant psychopathology or addiction pose still another ethical challenge. Systems therapy refrains from identifying problem behavior as located within an individual, and some empirically supported treatments address these problems through conjoint couple therapy (see, e.g., Chapters 24–26, in this volume). Nevertheless, some individual psychopathology can be more efficiently and effectively treated with individual therapy, and if that partner's functioning can be improved, the relationship may also improve. With individual psychopathology that is life-threatening (e.g., suicidal tendencies, adult anorexia), the priority is to reduce the immediate risk of harm, which may involve intensive individual therapy, perhaps with couple therapy as part of a comprehensive intervention (Baucom et al., 2017; Christensen et al., 2020). Transparently sharing available individual and couple options with the partners, and clearly identifying treatment goals, as well as whether partners are equal clients or one is in a collateral role, are essential steps in minimizing therapist–client misunderstandings.

As a whole, these contraindications for couple therapy bring up ethical issues concerning individual versus couple well-being. With each circumstance, pinpointing exactly when couple therapy is ill-advised may be difficult (e.g., what level of violence is too severe, whether ambivalence about staying in the relationship actually indicates a clear readiness to leave, and if individual psychopathology absolutely precludes productive couple work). These decisions are often quite nuanced and may take some time to sort out. Moreover, each partner's values (e.g., one person's resolve not to give up on the relationship), as well as the therapist's values (e.g., which relationships are worth saving), come into play. Though couple therapists rarely dictate or even verbalize whether a relationship should or should not continue, therapists need to be self-aware how their personal values and experiences might influence their therapeutic responses. Particularly when questions regarding whether to continue couple therapy resonate with personal experiences of the therapist (e.g., similar issues surrounding the therapist's recent divorce), outside consultation can be helpful to sort out the impact of the therapist's own experiences or, in some cases, to determine that the couple might be better served by a different therapist.

BOUNDARY ISSUES IN COUPLE THERAPY

Boundaries in couple therapy, as in individual therapy, pertain to the fundamental nature of the relationship between the therapist and each member of the couple, as well as relationships with persons known to both the therapist and both partners. Clear boundaries of providing psychotherapeutic services are breached if the therapist enters into a business relationship, friendship, or intimate relationship with a client, or with a close friend or relative of the client (Knapp et al., 2013). Maintaining clear boundaries is essential to the core principle of promoting couples' well-being and requires that couple therapists "are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons" (American Association for Marriage and Family Therapy, 2015, p. 2).

Though considerations surrounding multiple relationships have become more flexible and less prohibitive (Pope & Vasquez, 2016), couple therapists need to be careful of taking on someone as a client if they are associated with that person or someone close to that person in another capacity. A multiple relationship is to be avoided if it "could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (American Psychological Association, 2017a, p. 6). The consideration of boundaries is context-specific, however (Pope & Vasquez, 2016). In smaller communities with fewer therapists available, and even fewer therapists with expertise working with couples, the social networks of the therapist and couple may intersect (e.g., having a child at the same school). Similarly, a couple may seek a therapist who shares and thus understands some fundamental aspect of themselves or their relationship (e.g., a gay couple seeking a gay therapist, a couple with certain religious beliefs wanting a therapist who appreciates those beliefs, or a couple seeking a therapist who shares the same racial or ethnic identity). When the therapist and client couple are part of the same community—geographic or based on identity, chance encounters and overlapping personal networks may be difficult to avoid. Advance discussion of how these situations will be handled, should they occur, is advised.

In couple therapy, some boundary issues are more salient, and others are less salient. First, the boundary issue of multiple relationships is compounded simply because there are two clients, each with their own networks. Second, because the issues that couples bring to therapy may be familiar to therapists, who also are likely involved in intimate dyadic relationships, therapists may be inclined to share personal information. The question whether to self-disclose depends on what purpose is served by such disclosures. Therapist disclosures can be helpful for establishing the therapist's knowledge of certain situations and for building rapport. Alternatively, therapist disclosures can be a form of boundary violation if they are not made for the benefit of the client (Gutheil & Brodsky, 2008). Couple therapy, with its focus on the relationship between the clients, may be less at risk than individual therapy for boundary issues involving emotional and sexual attractions between the therapist and patient. Though strong feelings toward the therapist may be less prevalent in couple therapy than with individual therapy, they can still occur. When they do occur, the potential to derail couple therapy is strong. For example, a wife who perceives her husband to be flirting with the therapist may have difficulty trusting the therapist, especially if trust is a reason that the couple has sought therapy. Thus, couple therapists must have a high degree of self-awareness of what they are communicating, even unintentionally, to their clients. Couple therapists may need to address these issues through consultation and to consider whether they can continue to work with the couple.

Boundary issues also concern the type of information that clients seek about their therapists and the ways that clients want to establish a relationship with the therapist. Toward the beginning of couple therapy, clients sometimes ask personal questions about the therapist's marital status or whether the therapist has children. Although the therapist may perceive such questions as intrusive, what the clients may simply be asking is: Can you help us? Opinions vary regarding how to handle such questions, but in our view, answering these questions honestly, then pivoting to a discussion about how the therapist can be helpful or what the clients' concerns may be about the therapist is usually a good approach. Clients similarly may be curious about a therapist's credentials—again, likely with the hope of being assured that therapy might work for them. For most couples, therapy is a high-stakes endeavor, and clients are well-served by being informed consumers. Nowadays, clients potentially also have access to a lot of information about the therapist via the Internet. Therapists should not be surprised if clients come in for their first session knowing about them—their age, where they went to school, their professional achievements, and so on. Therapists need to be fully prepared that whatever they have made available for public access on the Internet also is accessible to their clients—who may simply be educating themselves about what to expect in therapy.

Further along in therapy or as therapy is ending, other potential boundary issues may arise. Clients may bring their couple therapist a gift—which in some forms of psychotherapy is highly discouraged. These gifts have different meanings to different clients and are best understood in the context of the clients' culture and beliefs, and what the gift is meant to convey. Expensive gifts can be problematic in terms of the therapist–couple dynamics, especially if the therapist feels indebted to the couple. However, small gifts, especially gifts of food or other homemade items, can be the clients' way of saying "thank you." Gracious acceptance can be validating and humanizing, whereas hard-and-fast no-gift rules can be rejecting and even shaming. Other clients sometimes wistfully indicate that they wish they could continue to see the therapists outside of the therapy situation: A couple in their 80s who showed a lot of improvement in therapy and were particularly fond of their graduate student co-therapists lightheartedly invited the therapists to their home for coffee. The therapists were definitely thinking "can't do!" but also understood the message behind the invitation—an expression of thanks to the therapists, along with some sadness and apprehension that therapy, which had been a positive experience in the clients' lives, was ending. Recognizing the sentiment behind this invitation, the therapists acknowledged that they, too, would miss seeing the couple, even as they articulated a clear therapy boundary that they could not socialize with them.

Sometimes, however, extenuating circumstances lead to exceptions about attending a family event with a current or prior therapy couple. Another co-therapy team was seeing a young couple that worked through some very serious issues in their relationship and in parenting their young child. Following couple therapy, the mother continued in therapy with another therapist at the same clinic and, just as the child was turning 3, an unspeakable tragedy occurred: The mother and child were in a car accident and the child lost his life. One of the couple therapists learned about the accident through the local news and was moved to consider attending the funeral. Seeking consultation, she received conflicting advice from different supervisors and realized that there was not a clear-cut right ethical decision; ultimately, this therapist decided to attend the funeral, staying in the background but showing her respect and caring through her presence. Such decisions highlight the difficult balance we sometimes face between maintaining professional boundaries and expressing our humanity, both of which need to be considered within the community and cultural context in which we practice.

TELEHEALTH AND INTERNET-BASED THERAPY

Demands for telepsychology, which already were increasing over the past decade or so (Koocher, 2007), became a leading mechanism for the delivery of psychotherapy with the COVID-19 pandemic (American Psychological Association, 2020a; Chenneville & Schwartz-Mette, 2020). Couple therapy is no exception. Prioritizing continuity of care with the need for social distancing has resulted in a rapid adaptation of in-person models of couple therapy to online formats. As yet, we lack information about whether online service delivery affects the treatment effectiveness or necessitates different paradigms for training couple therapists. In addition, beyond the online delivery of traditional couple therapy approaches, new technology-based interventions are increasingly available to expand opportunities for couple therapy services (see also Chapter 30, "Telehealth and Digital Couple Interventions," in this volume, by Doss et al.). These new therapy modalities are designed to make services available to more people by overcoming a number of logistical barriers associated with traditional models of therapy—that is, providing interventions that involve either limited or no contact with a human provider, reducing the cost, and making the timing of sessions more flexible. Recent data support the usefulness of these interventions with low-income and racial or ethnic minority couples (Christensen et al., 2020; Roddy, Rhoades, & Doss, 2020).

Even though some couple therapy models can remain generally unchanged in philosophy, objectives, and actual therapeutic activities in the transition to audio- or video-conferencing, additional ethical and legal considerations come to the forefront. Helpful guidelines (American Psychological Association, 2020a) are available that itemize considerations for conducting telepsychology, such as therapist and clients having physical space for a private telepsychology session, a Health Insurance Portability and Accountability (HIPAA)-compliant technology platform, a backup plan for technology failures, a safety plan including the clients' address and phone number in case of emergency, and therapists' competence with the technology of conducting telehealth. Consent forms for telepsychology need to address new confidentiality considerations (e.g., security of sessions and potential threats to security in the transfer of communications, data protection and storage), as well as boundaries regarding the therapist's availability via electronic means, disruptions in services, and fees for telehealth (American Psychological Association, 2013; Chenneville & Schwartz-Mette, 2020).

Since health care provider licensing is state- or nationally based, consideration of whether psychologists can provide services to clients who, either temporarily or permanently, are not physically in the same jurisdiction in which the provider is licensed is important (American Psychological Association, 2020b). In the United States, practicing telehealth across state lines (i.e., to a patient in a state other than where the mental health practitioner is licensed) requires careful investigation of state laws: Some states offer specific exceptions (e.g., number of days per year that an out-of-state psychologist may practice in a different state). Increasingly states are joining groupings such as the Psychology Interjurisdictional Compact (PSYPACT) that allow telepsychological services to patients in other PSYPACT states, and certain entities, such as the VA system, allow telehealth across state lines. Moreover, in response to COVID-19, many states relaxed regulations for interjurisdictional practice and issued emergency waivers allowing ongoing continued care across states. The rapid changes in laws about out-of-state practice require careful attention on a state-by-state basis, as well as different provisions for licensed therapists versus therapists in training. Insurance coverage across state lines also warrants attention to protect the couple, as well as the therapist.

Although administering conventional forms of couple therapy via telehealth has not been formally evaluated, our impression is that couples respond to telehealth with a high level of satisfaction and acceptance. Certain ethical considerations have arisen, however, that bear attention. Foremost, ensuring that the clients are in a private physical space is essential. At the start of each couple session, the therapist should verify the physical location of the couple. Having had one couple start a session while on a walk with their newborn and another start a session while driving in a car (i.e., raising issues of both privacy and safety), we believe that establishing where the couple is physically located at the start of each session is important—especially with features such as virtual backgrounds. If the couple is at home, ensuring that young children are separate yet safe is important, especially if there is not another adult in the household. If children or other adults are in the household, can they overhear the session? Have parents left the door open so that they can monitor what the children are up to while in the session? We have encountered situations in which a child was positioned off-camera but in the room with the parents as the session began, a child walked into the room unannounced midsession, and a child suddenly appeared in the video conference screen simply by clicking on a link that the parent had left open on another computer. Knowing that sound travels in certain homes, we have had to ask parents having a heated exchange to lower their voices so the children would not hear.

In general, video conferencing limits some of the nonverbal gestures that we rely on during in-person sessions. This is especially the case if the partners themselves are physically separated and log in from separate devices, with the result that they too are limited in terms of interpreting cues from one another.

High-conflict couples may pose extra risks during telepsychology, again due to limited access to some of signals that one or both partners are becoming distressed. Moreover, the familiarity of the home environment, which may be beneficial in terms of seeing the couple in their natural setting, also may increase the risk of more rapid escalation of conflict. Mostly, however, a partner who is highly frustrated can more easily leave the room or abruptly end a therapy session—another reason to have a contingency method for recontacting the couple or for triggering other emergency measures.

As described by Doss and colleagues (see Chapter 30, in this volume), asynchronous behavioral intervention technologies provide an alternative to face-to-face couple sessions—either in person or online. Largely automated, these interventions may rely totally on technology via apps or Web-based programs, or may include some human support via a therapist or coach. These interventions also vary in the extent to which they involve each partner engaging individually or require joint couple therapy activities. Depending on the specifics (e.g., how much human contact), these interventions may be thought of as therapy or as self-help programs. Licensure issues noted earlier may not apply if the intervention is considered a self-help program. Either way, however, some important, familiar ethical considerations may arise, in particular around privacy (e.g., Is the questionnaire information submitted encrypted? Are the video services HIPAA-compliant? Can the other partner or anyone else access the separate online communications of each partner?) and dangerousness (e.g., Might some of the joint couple activities trigger a serious conflict? Do certain online replies provide links to emergency services such as the National Domestic Violence Hotline?). (See Doss, Feinberg, Rothman, Roddy, & Comer, 2017, for further details.)

THERAPIST COMPETENCE

General Considerations

Simply stated, therapists who have not received training to do couple therapy run the risk of providing substandard therapy or even doing harm.

As already discussed here, and in other chapters in this *Handbook*, being a competent couple therapist requires an entirely different way of conceptualizing, framing, and conducting therapy, as contrasted with individual therapy (see also Chapter 1 on theory and practice of couple therapy by Lebow & Snyder). To be competent as a couple therapist means being knowledgeable about specific therapy approaches, while also being practiced at working from a systemic perspective in which everything that transpires in couple therapy reverberates within the couple system and likely beyond. Managing therapy sessions means simultaneously applying multiple lenses to monitor the process between the two partners, between each partner and the therapist, and between the couple as a unit and the therapist. Beyond what can be learned from books, initially practicing under the supervision of a skilled and experienced couple therapy supervisor and/or trainer is an essential step. Nonetheless, however well trained, our competence as couple therapists is continually being challenged and enhanced, as no two couples are alike and each couple has the potential to teach us something new.

In addition to acquiring expertise in the essentials of couple therapy, conducting couple therapy requires foundational knowledge in several other fields: adult development, psychopathology, health psychology, sexuality, and child development. The couple therapist needs enough knowledge in these other fields to recognize how they intersect with couple issues and to be aware when a referral to another professional for assessment or adjunctive treatment could be helpful to the couple. For example, work with a particular couple may require the therapist to understand how early signs of cognitive impairment might affect couple communication (see also Chapter 20 on aging, in this volume, by Knight), or to distinguish between the typical stresses on couples of living with a 2-year-old versus what might be a child's developmental disorder (see also Chapter 27 on disorders of childhood and adolescence, in this volume, by Wymbs, Wymbs, & Canu). A couple therapist also should be able to adequately assess for depression and the potential for self-harm to determine if individual or psychopharmacological interventions are first needed for safety concerns and for the couple therapy to have its intended effects (see also Chapter 26 on depression and anxiety, in this volume, by Whisman, Beach, & Davila). As much as couple therapists use a relational lens when formulating interventions, identifying the contextual, developmental, and health factors that intersect with couples' struggles are key to serving their best interests.

Multicultural Competence

The consideration of culture and race in couple therapy underscores core values such as social justice and the dignity of individuals; such contextualized understandings of couples' lives thus are essential to conducting ethical clinical practice with couples (Guillory, 2022; Kelly, 2017b; McGoldrick & Hardy, 2019; see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). In individual therapy, the importance of cultural competence is underscored by multiple mentions in documents such as the American Psychological Association's Ethical Principles and Code of Conduct (2017a) and its centrality in the Multicultural Guidelines, which provides "psychologists with a framework from which to consider evolving parameters for the provision of multiculturally competent services" (American Psychological Association, 2017b, p. 7). Providing multicultural care to couples is a complex process that requires expertise and self-awareness from therapists, who must consider the individual and intersecting cultural contexts of each partner and the couple, as well as how their own backgrounds and identities are unavoidably part of the therapeutic relationship.

Cultural Context

According to the American Psychological Association's ethical principles on competence, "an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of services" and "psychologists [are to] have or obtain the training, experience, consultation or supervision necessary to ensure the competency of their services, or they make appropriate referrals" [Standard 2.01b](2017a, p. 5). Moreover, culture may be broadly defined to include additional contexts that inform an individual's principle values and personal standards, such as occupation (e.g., military culture), political leaning or party affiliation, geographical region (e.g., urban vs. rural), and other values-based identities (e.g., feminist). With so many considerations, the guideline regarding cultural competence is aspirational for individual therapy and even more challenging in couple therapy. Given the inherent nature of a couple—a relationship between two unique individuals—couples themselves are, by definition, multicultural. Therapists need to take into account the intersectionality of multifaceted identities within each person, as well as the coming together of identities between the two partners. This is complicated further "because our cultural identities do not involve some clearly measured and thoroughly blended parts but rather an ever-changing mixture of identities, some of which may have particular prominence in a given context, whereas a different aspect may come to the fore under other circumstances" (McGoldrick & Hardy, 2019, p. 13).

The ways that couples live their lives are inseparable from identity and culture. Identity, as shaped by culture, is integral to how partners define their roles, make decisions, communicate verbally and nonverbally, attend to and express emotions, parent their children, and interact with extended family members; identity also may underlie couple conflicts in these and other areas. Awareness of culture thus helps us better understand couples' issues, as well as identify their strengths. As partners join their lives, they negotiate their diverse cultures in most every aspect of their lives together—from the food they eat to their essential values and beliefs. Outside their homes, many couples also have to contend with the ways they are viewed and perhaps judged by the larger culture, for example, the reactions a multiracial couple or same-sex couple might encounter simply walking down the street or trying to rent or buy a home together. A further reality for couple therapy is that fundamental ideas about couples, romantic relationships, marriage, and so forth, are culturally defined. Couples may seek therapy due to a clash stemming from their cultural values, even if they themselves do not label the conflict that way.

Nonetheless, to a large extent, couple therapy models have not developed or organized their formulations of couple problems and interventions with these identity factors as priority considerations. Despite the systemic perspectives of most couple therapists for understanding phenomena within the couple and family, larger societal and cultural systems and structures are often overlooked. Moreover, studies supporting couple therapy models generally have been tested with samples that are predominantly White, opposite-sex couples and with therapists who typically are White—raising questions about the applicability and generalizability of the evidence supporting current models for non-White, non-Eurocentric, non-opposite-sex couples (see also Chapter 23 on queer couples, in this volume, by Coolhart). Clinically, universalizing couples' experience (e.g., treating everyone the same) based on what is known about majority or White couples and failing to make culture part of the therapeutic conversation disregards so much of what makes people and couples unique (Akamatsu, 2019). Ethically, such oversights risk violating guidelines such as the American Psychological Association's Guideline on Respect for People's Rights and Dignity [Principle E]: "Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups" (2017a, p. 4).

Inattentiveness to cultural and individual differences in our couple therapy models also risks inadvertently communicating to couples of underserved populations that couple therapy was not designed with them in mind and perhaps even limiting who seeks our services. For those who do seek therapy, such inattentiveness risks making errors due overpathologizing, minimizing, overdiagnosing, and underdiagnosing (Comas-Díaz, 2012). Important directions for couple therapy include getting beyond the pervasiveness of "Whiteness" in couple therapy formulations and training, and increasing responsiveness to couples that heretofore have been marginalized, viewed as "other," or been invisible in the development of couple therapy.

Therapist's Self-Awareness of Culture and Values

As therapists, as well as educators and students in couple therapy, we need to be mindful of ourselves as cultural beings who "hold attitudes and beliefs that can influence perceptions of and interactions with others as well as clinical and empirical conceptualizations" [Guideline 2] (American Psychological Association, 2017b, p. 4). We bring our own cultural lens, which affects the ways we think about and interact with couples, and which might align more with one or another partner. Cultural self-awareness thus is important in examining how our own attitudes, values, and behaviors affect our reactions in therapy to each member of the couple. Such self-awareness also helps us appreciate couples' perceptions of us, and the choices that they may make about what to disclose in therapy.

Moreover, as couple therapists, we must remain cognizant of the power we wield and the ways that our values and beliefs influence our behaviors as therapists. Any therapeutic relationship involves risks of miscommunication or cultural misattunement, particularly when therapists are relating to people from different backgrounds or cultures (Comas-Diaz, 2012; see also Chapter 12, "Socioculturally Attuned Couple Therapy," in this volume, by Knudson-Martin & Kim). In couple therapy, however, an added risk is that these missteps come at the expense of one partner while benefiting the other. Couple therapy is replete with moments when the weight of the therapist's words or the therapist's silence can send a strong and different message to each partner, and these messages can be extremely important when they involve the identities of one or both partners. What different messages are sent if a therapist does versus does not challenge, or even validates, a male partner's comments that his partner is "too emotional"? Relatedly, what is the impact on the therapeutic relationship with each partner if the therapist privately writes off the husband as sexist? And how are clients' reactions to the therapist differentially perceived in light of the therapist's gender or perhaps a racial match with one but not the other partner? In other instances, the couple may be in agreement (e.g., both partners subscribing to traditional sex roles), while a therapist may communicate a negative judgment about that, even in very subtle ways. Such fleeting yet ever-so-common moments not only reflect something important about the couple process, but they also expose important cultural constructions.

Recognizing and figuring out when and how to address the role of personal identities and cultural background in the couple therapy room unquestionably are daunting tasks. However, neutralizing or ignoring remarks that are insensitive, or a direct attack on one partner's identity, can have the unwanted and even harmful impact of reinforcing identity-based biases, fostering more animosity between partners and perhaps causing one partner to emotionally retreat from therapy. Ethical guidelines provide only broad recommendations reminding us to be conscious of and sensitive to individual and cultural differences and to be self-aware. Kelly (2017a, p. 457) for one, offers a helpful and specific road map toward cultural competence through four interrelated mechanisms: gaining knowledge about diverse couples' worldviews and values; understanding each couple's unique experiences and contexts; identifying power differentials within the couple and between the therapist and the couple; and minimizing the "felt difference" between the couple and therapist. Yet, as Brown (2013, p. 141) cautions, "One does not *achieve* cultural competence. . . . Cultural competence, like ethics, is largely aspirational in nature. Although there are some specific rules of cultural competence, just as there are multiple specific and enforceable ethical standards, the heart and soul of culturally competent practice must be seen as a stance in relationship to one's work that leaves the clinician in a state of continuous evolution, a broadening awareness of self, and an increasing willingness to accept that the more one knows, the more one knows one doesn't know much at all."

CONCLUDING COMMENTS

Good ethical practice and good couple therapy go hand in hand. Ethics in clinical practice sometimes is erroneously relegated to a necessary but routine dimension of therapy—irksome details to get through as quickly as possible. Indeed, the consent process does take up precious time during the initial session, when everyone is eager to talk about the couple's concerns. Moreover, many individuals are accustomed to signing "I agree" to wide-ranging consent forms without reading or understanding the documents. For this reason, we recommend that essential information in the consent process be communicated in a straightforward and plain-spoken fashion. We further recommend that the therapist convey that the overriding goal of ethical practice and consent is to protect the well-being of the separate individuals and the couple. As such, discussions of ethics can be an important first step in setting the tone for the therapist–couple relationship. The actual enactment of ethical principles, however, is not just an initial conversation but a dynamic process wherein different dimensions of ethical decision making come into focus at different times during the course of couple therapy. As both seasoned and beginning couple therapists come to know, conducting therapy with distressed couples is anything but formulaic, and the same is true for ethical decision making in couple therapy. Every couple seen in therapy has the potential to present new challenges and new opportunities to learn how to be an effective and ethical therapist.

SUGGESTIONS FOR FURTHER STUDY

American Association for Marriage and Family Therapy. (2015). *Code of ethics*. www.aamft.org/legal_ethics/code_of_ethics.aspx.

American Psychological Association. (2013). Guidelines for the practice of telepsychology. *American Psychologist, 68,* 791–800.

American Psychological Association. (2017). *Ethical principles and code of conduct.* www.apa.org/ethics/code.

Kelly, S. (Ed.). (2017). *Diversity in couple and family therapy.* Santa Barbara, CA: Praeger.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.

McGoldrick, M., & Hardy, K. V. (Eds.). (2019). *Re-visioning family therapy: Addressing diversity in clinical practice* (3rd ed.). New York: Guilford Press.

REFERENCES

Adi, A., & Mathbout, M. (2018). Duty to protect: Four decades after Tarasoff. *American Journal of Psychiatry Residents' Journal, 13,* 6–8.

Akamatsu, N. N. (2019). Teaching about racism and the implications for practice. In M. McGoldrick & K. V. Hardy (Eds.), *Re-visioning family therapy: Addressing diversity in clinical practice* (3rd ed., pp. 512–525). New York: Guilford Press.

American Association for Marriage and Family Therapy. (2015). *Code of ethics.* www.aamft.org/legal_ethics/code_of_ethics.aspx.

American Psychological Association. (2002). Criteria for practice guideline development and evaluation. *American Psychologist, 57,* 1048–1051.

American Psychological Association. (2010). Guidelines for child custody evaluations in family law proceedings. *American Psychologist, 65,* 863–867.

American Psychological Association. (2013). Guidelines for the practice of telepsychology. *American Psychologist, 68,* 791–800.

American Psychological Association. (2017a). *Ethical principles and code of conduct.* https://www.apa.org/ethics/code.

American Psychological Association. (2017b). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality.* www.apa.org/about/policy/multicultural-guidelines.pdf.

American Psychological Association. (2020a). *APA COVID-19 information and resources.* www.apa.org/topics/covid-19.

American Psychological Association (2020b). *COVID-19: Is it legal to treat clients in another state?* www.apaservices.org/practice/clinic/covid-19-treating-clients?_ga=2.169690849.1362295401.1608486950–225654017.1606244101.

American Psychological Association Practice Organization. (2014, Winter). More than two people in the room: Legal and ethical issues when working with couples, families and groups. *Good Practice,* pp. 2–5, 20.

Baucom, D. H., Fischer, M. S., Corrie, S., Worrell, M., & Boeding, S. E. (2020). *Treating relationship distress and psychopathology in couples: A cognitive-behavioural approach.* New York: Routledge.

Baucom, D. H., Kirby, J. S., Fischer, M. S., Baucom, B. R., Hamer, R., & Bulik, C. M. (2017). Findings from a couple-based open trial for adult anorexia nervosa. *Journal of Family Psychology, 31,* 584–591.

Baucom, D. H., Kirby, J. S., & Kelly, J. T. (2009). Couple-based interventions to assist partners with psychological and medical problems. In K. Hahlweg, M. Grawe, & D. H. Baucom (Eds.), *Enhancing couples: The shape of couple therapy to come* (pp. 79–93). Göttingen, Germany: Hogrefe.

Baucom, D. H., Snyder, D. K., & Gordon, K. C. (2009). *Helping couples get past the affair.* New York: Guilford Press.

Bradbury, T. N., & Bodenmann, G. (2020). Intervention for couples. *Annual Review of Clinical Psychology, 16,* 99–123.

Bragg, H. L. (2003). *Child protection in families experiencing domestic violence.* U.S. Department of Health and Human Services. www.childwelfare.gov/pubpdfs/domesticviolence2003.pdf.

Brown, L. S. (2013). Compassion amidst oppression: Increasing cultural competence for managing difficult dialogues in psychotherapy. In A. W. Wolf, M. R. Goldfried, & J. C. Muran (Eds.), *Transforming negative reactions to clients: From frustration to compassion* (pp. 139–158). Washington, DC: American Psychological Association.

Chenneville, T., & Schwartz-Mette, R. (2020). Ethical considerations for psychologists in the time of COVID-19. *American Psychologist, 75,* 644–654.

Christensen, A., Doss, B. D., & Jacobson, N. S. (2020). *Integrative behavioral couple therapy: A therapist's guide to creating acceptance and change.* New York: Norton.

Christensen, A., & Glynn, S. (2019). Integrative behavioral couple therapy. In B. H. Fiese (Editor-in-Chief), *APA handbook of contemporary family psychology: Vol. 3. Family therapy and training* (pp. 275–290). Washington, DC: American Psychological Association.

Comas-Díaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence.* Washington, DC: American Psychological Association.

Davies, P. T., & Cummings, E. M. (1994). Marital conflict and children: An emotional-security perspective. *Psychological Bulletin, 116,* 387–411.

Doherty, W. J. (1995). *Soul searching: Why psychotherapy must promote moral responsibility.* New York: Basic Books.

Doherty, W. J., Harris, S. M., & Wilde, J. L. (2016). Discernment counseling for "mixed-agenda" couples. *Journal of Marital and Family Therapy, 42,* 246–255.

Doss, B. D., Feinberg, L. K., Rothman, K. I., Roddy, M. K., & Comer, J. (2017). Using technology to enhance and expand interventions for couples and families: Conceptual and methodological considerations. *Journal of Family Psychology, 31,* 983–993.

Gottlieb, M. C., Lasser, J., & Simpson, G. L. (2008). Legal and ethical issues in couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 698–717). New York: Guilford Press.

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28,* 50–57.

Grych, J. H., & Fincham, F. D. (Eds.). (2001). *Child development and interparental conflict* (pp. 9–38). Cambridge, UK: Cambridge University Press.

Guillory, P. T. (2022). *Emotionally focused therapy with African American couples—Love heals.* New York: Routledge.

Gutheil, T. G., & Brodsky, A. (2008). *Preventing boundary violations in clinical practice.* New York: Guilford Press.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). *Children of battered women.* Newbury Park, CA: SAGE.

Johnson, S., & Lebow, J. (2000). The "coming of age" of couple therapy: A decade review. *Journal of Marital and Family Therapy, 26,* 23–38.

Kelly, S. (2017a). Conclusions drawn from the experts on tailoring treatment to diverse couples and families. In S. Kelly (Ed.), *Diversity in couple and family therapy* (pp. 453–467). Santa Barbara, CA: Praeger.

Kelly, S. (Ed.). (2017b). *Diversity in couple and family therapy.* Santa Barbara, CA: Praeger.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.

Koocher, G. P. (2007). Twenty-first century ethical challenges for psychology. *American Psychologist, 62,* 375–384.

Lebow, J. L. (2019). Ethics and values [Couple and family therapy]. In E. Y. Drogin (Ed.)., *Ethical conflicts in psychology* (5th ed., pp. 472–477). Washington, DC: American Psychological Association.

Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. *American Psychologist, 37,* 788–801.

Margolin, G. (1986). Ethical issues in marital therapy. In N. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 621–638). New York: Guilford Press.

Margolin, G. (1998). Ethical issues in marital therapy. In R. M. Anderson, T. L. Needels, & H. V. Hall (Eds.) *Avoiding ethical misconduct in psychology specialty areas* (pp. 78–94). Springfield, IL: Charles C Thomas.

Margolin, G., Shapiro, L.S., & Miller, K. (2015). Ethics in couple and family psychotherapy. In J. Sadler, B. Fulford, & C. W. Van Staden (Eds.), *Oxford handbook of psychiatric ethics* (Vol. 2, pp. 1306–1314). New York: Oxford University Press.

Marín, R. A., Christensen, A., & Atkins, D. C. (2014). Infidelity and behavioral couple therapy: Relationship outcomes over 5 years following therapy. *Couple and Family Psychology: Research and Practice, 3,* 1–12.

McGoldrick, M., & Hardy, K. V. (Eds.). (2019). *Re-visioning family therapy: Addressing diversity in clinical practice* (3rd ed.). New York: Guilford Press.

National Association of Social Workers. (2017). *Code of Ethics.* www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english.

O'Leary, K. K., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriage: The need for multimodal assessment. *Behavioral Assessment, 14,* 5–14.

Pope, K. S., & Vasquez, M. J. T. (2016). *Ethics in psychotherapy and counseling: A practical guide* (5th ed.). Hoboken, NJ: Wiley.

Roddy, M. K., Rhoades, G. K., & Doss, B. D. (2020). Effects of ePREP and OurRelationship on low-income couples' mental health and health behaviors: A randomized controlled trial. *Prevention Science, 21,* 861–871.

Roddy, M. K., Walsh, L. M., Rothman, K., Hatch, S. G., & Doss, B. D. (2020). Meta-analysis of couple therapy: Effects across outcomes, designs, time frames, and other moderators. *Journal of Consulting and Clinical Psychology, 88,* 583–596.

Rohrbaugh, M. J. (2021). Constructing We-ness: A communal coping intervention for couples facing chronic illness. *Family Process, 60,* 17–31.

Simpson, L. E., Doss, B. D., Wheeler, J., & Christensen, A. (2007). Relationship violence among couples seeking therapy: Common couple violence or battering? *Journal of Marital and Family Therapy, 33,* 270–283.

Snyder, D. K., & Doss, B. D. (2005). Treating infidelity: Clinical and ethical directions. *Journal of Clinical Psychology, 61,* 1453–1465.

Weinstock, R., Bonnici, D., Seroussi, A., & Leong, G. B. (2014). No duty to warn in California: Now unambiguously solely a duty to protect. *Journal of the American Academy of Psychatry and Law, 42*, 101–108.

Wile, D. B. (2013). *After the fight: A night in the life of a couple.* New York: Guilford Press.

Wolska, M. (2011). Marital therapy/couples therapy: Indications and contra-indications. *Archives of Psychiatry and Psychotherapy, 13,* 57–64.

Index

Note. Page numbers followed by *f* or *t* indicate a figure or a table.

Ability/disability, 268, 461, 462–465, 467, 469, 621–622. *See also* Identity-related factors; Medical issues
Abuse within the relationship. *See* Intimate partner violence (IPV)
Acceptance
  acceptance and commitment couple therapy and, 108, 112
  common factors in couple and family therapy and, 305
  divorce therapy and, 482–483
  emotionally focused couple therapy and, 127
  focus of intervention and, 14
  Gottman method and, 371–372
  integrative behavioral couple therapy and, 80, 81–82, 83, 94
  intergenerational couple therapy and, 215–216
  medical issues and, 621, 629
  mentalization-based couple therapy and, 187
  overview, 17
  tolerance building and, 93–94
Acceptance and commitment couple therapy
  assessment, treatment planning, and goal setting and, 111–114, 113*f*
  case illustration, 119–122
  dyadic techniques employed in, 109–110
  empirical support for, 118–119
  evolution of couple therapies, 8
  healthy versus distressed relationships and, 105–108
  overview, 17, 104–105, 122
  practice of, 108–118, 113*f*
  processes and mechanisms of change and, 108–109
  role of therapist and, 110–111
  strategic focus of, 114–118
Acceptance and commitment therapy (ACT), 34, 104–105, 108–109. *See also* Acceptance and commitment couple therapy
Accommodation
  ADHD and disruptive behavior disorders parenting concerns and, 601
  cognitive-behavioral conjoint therapy for PTSD, 545
  cognitive-behavioral couple therapy and, 69, 70
  depression or anxiety and, 579, 585, 586, 587, 588–589
  posttraumatic stress disorder (PTSD) and, 535
  socioculturally attuned couple therapy and, 272
Accountability, 279*f*, 281–283
Accusations, 90, 91
ACT Matrix technique, 113–114, 113*f*
"Acting as if" intervention, 303
Action metaframework, 327, 328
Actor–observer bias, 535. *See also* Bias
Adaptations, 203, 618–620, 621–622, 627–628
Addiction, 138–139, 141, 156, 217–218. *See also* Alcohol use; Substance abuse; Substance use disorders (SUDs)
ADHD parenting concerns
  applicability and empirical support for treatment with, 606–607
  assessment and treatment planning and, 601–603
  case illustration, 607–611
  core understandings about, 597–598
  goal setting, 603–604
  mechanisms of change and, 606
  overview, 595–597, 611–612
  practice of couple therapy for, 598–606
  process and technical aspects of working with, 604–606
  role of therapist and, 600–601
  structure of, 599–600
  See also Attention-deficit/hyperactivity disorder (ADHD); Behavioral parent training (BPT); Parenting concerns
ADHD Rating Scale–5, 602

Adjunct treatments, 639–640, 665–669
Adult ADHD Self-Report Scale (ASRS), 602
Adult children
  boundaries and, 212–213
  differences across approaches and, 12
  divorce and divorce therapy and, 473–474, 479
  family-of-origin relationships and, 216–217
  intergenerational couple therapy and, 212–218
  stepfamily couples and, 507–508
Adult couples, older. *See* Older adult couples
Advance directives, 632
Affairs. *See* Infidelity
Affect, 7, 23–26, 24*t*–25*t*, 31, 185, 366–367
Affection, 365, 375, 497
Affirmation, 371–372
African American couples, 8, 506, 650–651. *See also* Cultural factors; Ethnicity; Race; Stepfamily couples
Age
  age differences in couples, 458, 459
  ageism, 457, 467–468
  alcohol behavioral couple therapy and, 566
  cognitive-behavioral conjoint therapy for PTSD, 540
  intersectional framework and, 514
  narrative couple therapy and, 232, 234
  socioculturally attuned couple therapy and, 268
  See also Identity-related factors; Older adult couples
Agency, 259, 619, 627–628
Aggression
  acceptance and commitment couple therapy and, 112, 118
  applicability and empirical support for couple therapy for, 404–406
  assessment and treatment planning and, 24*t*, 30, 33, 396–398
  case illustration, 406–409
  cognitive-behavioral conjoint therapy for PTSD and, 541, 543, 545–546
  cognitive-behavioral couple therapy and, 61, 70–71
  core understandings about, 393–394
  depression or anxiety and, 584, 587
  emotionally focused couple therapy and, 130
  ethical considerations and, 687–688, 689
  forms of, 392
  goal setting, 398–399
  infidelity and, 413, 417, 420
  integrative behavioral couple therapy and, 89
  overview, 391–393, 409–410
  practice of couple therapy for, 394–404
  therapeutic palette integrative approach and, 343
  See also Intimate partner violence (IPV); Partner aggression; Violence
Aging couples. *See* Older adult couples
Alcohol behavioral couple therapy (ABCT)
  applicability and empirical support for, 568–569
  assessment and treatment planning and, 559–561, 566
  case illustration, 569–573, 571*f*
  core understandings about, 555–557
  goal setting, 561
  mechanisms of change in, 567–568
  overview, 554–555, 573
  practice of, 557–567, 558*t*
  process and technical aspects of, 561–567
  role of therapist and, 558–559, 566–567
  structure of, 557–558, 558*t*
  See also Alcohol use
Alcohol use
  assessment and, 34
  case illustration, 569–573, 571*f*
  cognitive-behavioral couple therapy and, 70, 73
  core understandings about, 555–557
  overview, 554–555, 573
  See also Addiction; Alcohol behavioral couple therapy (ABCT); Alcohol use disorder (AUD); Substance abuse
Alcohol use disorder (AUD), 556–557, 565, 573. *See also* Alcohol use; Substance use disorders (SUDs)
Alcoholics Anonymous (AA), 563, 567
Alliance predominance guideline, 330–331, 331*t*. *See also* Therapeutic alliance/relationship
Ambivalence
  alcohol behavioral couple therapy and, 566–567
  contraindications for couple therapy, 689
  divorce and, 476
  infidelity and, 420
  object relations couple therapy and, 160
  therapeutic palette integrative approach and, 349
American Indian/Alaska Native populations, 651. *See also* Cultural factors
American Psychological Association, 297. *See also* Ethical considerations
Anger
  aggression and, 392, 401–402, 403
  alcohol behavioral couple therapy and, 559, 565, 567
  anger management, 395, 404, 482
  emotionally focused couple therapy and, 130
  empathic joining and, 90
  Gottman method and, 366, 372
  infidelity and, 421, 424
  intergenerational couple therapy and, 216
  medical issues and, 627
  object relations couple therapy and, 157–158
  in sessions, 29–30
  therapeutic palette integrative approach and, 344

Anxiety
  aggression and, 394
  applicability and empirical support for couple therapy for, 587, 588–589
  Bowen therapy and, 200
  case illustration, 589–591
  common factors in couple and family therapy and, 303
  core understandings about, 577–580
  emotionally focused couple therapy and, 138–139
  infidelity and, 413, 414, 420, 421
  mechanisms of change in the treatment of, 587
  overview, 53, 576, 591
  practice of couple therapy for, 580–586
  stepfamily couples and, 505–506
  See also Anxiety disorders; Couple therapy for anxiety or depression; Mental health
Anxiety disorders, 3, 69–70, 557, 576. *See also* Anxiety
Anxious attachment, 299–300
Anxious-preoccupied attachment, 377. *See also* Attachment
Apology, 203, 215–216
Appraisals, 535, 545
Appreciation, 370, 374, 583
Areas of Change Questionnaire, 560
Arousal, 177, 495
Assessment
  acceptance and commitment couple therapy and, 111–114, 113*f*
  ADHD and disruptive behavior disorders parenting concerns and, 601–603
  aggression and, 396–398, 404, 405
  alcohol behavioral couple therapy and, 559–562, 565
  applicability and empirical support, 34–37
  case illustration, 37–45, 42*f*
  cognitive-behavioral conjoint therapy for PTSD and, 538, 539–541
  cognitive-behavioral couple therapy and, 59–61
  depression or anxiety and, 580–582
  differences across approaches and, 11, 12
  digital couple interventions and, 665–666
  divorce and, 476–477
  emotionally focused couple therapy and, 133–134
  Gottman method and, 362, 363–364, 380–381
  guidelines for, 26–27, 30
  infidelity and, 418–420
  integrative behavioral couple therapy and, 82, 84–89, 86*t*
  integrative systemic therapy and, 323–324, 331*t*
  intergenerational couple therapy and, 206–207
  medical issues and, 625–627, 625*t*
  mentalization-based couple therapy and, 179, 181
  narrative couple therapy and, 231–232
  object relations couple therapy and, 157–160, 161–163
  observational methods, 30–31
  older adult couples and, 464–465, 468–469
  overview, 8–9, 22–26, 24*t*–25*t*, 34, 45
  role of therapist and, 27
  self-report methods, 31–34
  sex therapy and, 440–442, 443*t*
  socioculturally attuned couple therapy and, 273, 275–278
  solution-focused couple therapy and, 254–255
  stepfamily couples and, 503–504
  structure of, 27–34
  telehealth and, 659–660, 667–668
  temporal framework and, 14–15
  therapeutic palette integrative approach and, 346, 348–349
Assumptions, 23, 65–66, 401, 415, 626–627
Atone–attune–attach therapy, 365
Attachment
  aggression and, 392
  assessment and, 33, 134
  attachment theory, 129, 140, 374
  common factors in couple and family therapy and, 299–300
  convergence of methods and, 6
  emotionally focused couple therapy and, 129, 131, 132–133, 135–136, 140
  Gottman method and, 375, 377
  healthy versus distressed relationships and, 130–131
  mentalization-based couple therapy and, 188
  overview, 7, 9
  socioculturally attuned couple therapy and, 271*t*
  stepfamily couples and, 497–498, 502
Attachment bonds, 130–131
Attachment injury resolution model (AIRM), 136
Attention-deficit/hyperactivity disorder (ADHD)
  assessing for, 601–602
  behavioral parent training (BPT) and, 606
  case illustration, 607–611
  core understandings about, 597–598
  object relations couple therapy and, 156
  overview, 311–312, 595–596
  See also ADHD parenting concerns
Attributions, 23, 55–56, 482
Attunement
  Circle of Care and, 270, 272, 272*f*
  Gottman method and, 365
  mentalization-based couple therapy and, 180*t*
  object relations couple therapy and, 171
  socioculturally attuned couple therapy and, 274, 276, 279–280, 279*f*, 281–283
Automatic thoughts, 65–66, 401. *See also* Thoughts
Autonomy, 129, 200, 211–212
Avoidance
  acceptance and, 17
  acceptance and commitment couple therapy and, 108, 112, 118–119

Avoidance (*continued*)
  alcohol behavioral couple therapy and, 567
  assessment and, 30–31
  cognitive-behavioral conjoint therapy for PTSD, 537, 538, 544
  depression and, 578
  depression or anxiety and, 577, 585–586
  infidelity and, 425
  medical issues and, 620, 629
  mentalization-based couple therapy and, 178
  posttraumatic stress disorder (PTSD) and, 535
  splitting and, 158
  telemental health and, 663
Avoidant attachment, 299–300, 377

B

Behavioral and control construct domain, 23–26, 24*t*–25*t*
Behavioral approaches, 11–15
Behavioral couple therapy (BCT), 53–54, 554
Behavioral marital therapy, 7
Behavioral parent training (BPT)
  applicability and empirical support for, 606–607
  assessment and treatment planning and, 601–603
  case illustration, 607–611
  components of, 605–606
  goal setting, 603–604
  mechanisms of change in, 606
  overview, 596, 611–612
  practice of child-focused couple therapy and, 598–606
  process and technical aspects of, 604–606
  role of therapist and, 600–601
  structure of, 599–600
  See also ADHD parenting concerns; Attention-deficit/hyperactivity disorder (ADHD); Disruptive behavior disorders parenting concerns; Parenting concerns
Behavioral patterns and change
  acceptance and commitment couple therapy and, 109
  ADHD and disruptive behavior disorders parenting concerns and, 604
  aggression and, 394, 400
  assessment and, 24*t*
  divorce therapy and, 481
  emotionally focused couple therapy and, 128
  focus of intervention and, 14
  healthy versus distressed relationships and, 55–56
  integrative behavioral couple therapy and, 79–80
  integrative systemic therapy and, 320
  intergenerational couple therapy and, 217
  interventions for in CBCT, 62–64, 64*t*, 66
  overview, 6
  posttraumatic stress disorder (PTSD) and, 535
  See also Change and change mechanisms
Behavioral problems in children, 595–597. *See also* ADHD parenting concerns; Disruptive behavior disorders parenting concerns; Parenting concerns
Beliefs
  assessment and, 23
  cognitive-behavioral couple therapy and, 55–56, 65–66
  common factors in couple and family therapy and, 303
  Gottman method and, 382
  infidelity and, 414
  mentalization-based couple therapy and, 188
  object relations couple therapy and, 154, 163–165
  therapeutic palette integrative approach and, 344
  See also Cognitions; Values
Betrayal, 365, 415, 421, 424, 425–426, 448
Bias
  divorce and, 477–478
  emotionally focused couple therapy and, 139
  intergenerational couple therapy and, 216
  levels of intervention and, 13
  mentalization-based couple therapy and, 188
  older adult couples and, 467–468
  posttraumatic stress disorder (PTSD) and, 535
  self-report methods of assessment and, 32
  sexuality and, 18
Biobehavioral metaframework, 327, 329
Biofeedback, 370, 371
Biopsychosocial model, 6, 435, 442, 443*t*, 615–616, 616*f*
Bipolar disorder, 156, 394, 587
Bisexuality, 512–513, 522–523, 526–527. *See also* Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples; Queer couples
Black American couples, 8, 506, 650–651. *See also* Cultural factors; Ethnicity; Race; Stepfamily couples
Blame
  aggression and, 391–392, 396, 399
  depression or anxiety and, 578, 584, 586
  intergenerational therapy and, 202–203, 206, 208–209
  "the magic question" and, 211
  medical issues and, 628–629
  narrative couple therapy and, 235
  object relations couple therapy and, 151–152, 160
  socioculturally attuned couple therapy and, 274
  unified detachment and, 91
Blended families. *See* Stepfamily couples
Booster sessions, 567, 605
Borderline personality disorders and tendencies, 151–152, 155, 557
Both–and position, 185, 476, 497
Boundaries
  aggression and, 403
  ethical considerations and, 690–692
  integrative systemic therapy and, 325
  intergenerational couple therapy and, 212–213, 215, 216

  medical issues and, 630
  telemental health and, 659–660
  trans partners and, 524
Bowen therapy, 8, 200, 215, 299–300
Brief Family Therapy Center (BFTC), 250
Brief Symptom Inventory (BSI), 33–34, 397

C

Care needs, 461–465, 508
Caregiving, 462–465, 556, 620–622. *See also* Medical issues
Case formulation
  alcohol behavioral couple therapy and, 560–561
  assessment and, 29
  cognitive-behavioral couple therapy and, 59, 61
  differences across approaches and, 12
  integrative behavioral couple therapy and, 84–85, 87–88
  mentalization-based couple therapy and, 179–180
  overview, 45
Change and change mechanisms
  acceptance and, 17
  acceptance and commitment couple therapy and, 105–106, 108–109
  ADHD and disruptive behavior disorders parenting concerns and, 606
  aggression and, 404
  alcohol behavioral couple therapy and, 564, 566–568
  cognitive-behavioral conjoint therapy for PTSD, 544–545
  cognitive-behavioral couple therapy and, 71–72
  common factors in couple and family therapy and, 309–310
  depression or anxiety and, 586–587
  divorce therapy and, 481, 487
  emotionally focused couple therapy and, 131, 137–138
  Gottman method and, 380
  infidelity and, 424–425
  integrative behavioral couple therapy and, 83, 92–95
  integrative systemic therapy and, 332–333
  intergenerational couple therapy and, 217
  medical issues and, 631
  mentalization-based couple therapy and, 186–188
  narrative couple therapy and, 242
  object relations couple therapy and, 172
  overview, 14
  sex therapy and, 447–448
  socioculturally attuned couple therapy and, 274, 279*f*, 283–284
  solution-focused couple therapy and, 261
  stepfamily couples and, 497, 501
  therapeutic palette integrative approach and, 347, 350, 352–354
Change entry points (thoughts, emotions, or behavior), 11, 341–342, 359
Child Behavior Checklist (CBCL), 34, 602
Child-focused couple therapy
  ADHD and disruptive behavior disorders parenting concerns and, 598, 600
  assessment and treatment planning and, 601–603
  goal setting, 603–604
  practice of, 598–606
  process and technical aspects of, 604–606
  role of therapist and, 600–601
  structure of, 599–600
  See also ADHD parenting concerns; Parenting concerns
Children
  approaches to couple therapy and, 12, 16
  assessment and, 34
  divorce therapy and, 477, 479, 480, 483–484
  effects of couple distress on, 3, 11
  ethical considerations and, 685, 687–688, 693
  intergenerational couple therapy and, 204
  mentalization-based couple therapy and, 175, 188
  queer couples and, 518–519
  relationship education and, 640
  stepfamily couples and, 496–498, 501–502, 505
  telehealth and, 659–660, 693
  See also ADHD parenting concerns; Disruptive behavior disorders parenting concerns; Parenting concerns
Choice, 127–128, 203, 210
Circle of Care, 270, 272–273, 272*f*, 276–277, 278, 279, 283, 285, 286–289
Class factors, 8, 232, 234, 268
Client factors, 19, 205–206, 304–305
Clinical interview
  acceptance and commitment couple therapy and, 112–114, 113*f*
  ADHD and disruptive behavior disorders parenting concerns and, 601
  alcohol behavioral couple therapy and, 559–560
  case illustration, 37–41
  cognitive-behavioral couple therapy and, 59–61
  integrative behavioral couple therapy and, 85–87, 86*t*
  overview, 22–23, 27–30
  semistructured interviews, 26
  sex therapy and, 442
  See also Assessment
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), 539–540
Coaching
  aggression and, 404
  cognitive-behavioral conjoint therapy for PTSD, 539
  digital couple interventions and, 665–666, 671
  integrative behavioral couple therapy and, 83
  medical issues and, 630
  relationship education programs and, 641
  See also Therapist
Coercion, 81, 435*n*
Cognitions, 55–56, 64–66, 537. *See also* Thoughts

Cognitive construct domain, 23–26, 24*t*–25*t*
Cognitive functioning, 545
  aggression and, 394, 400–401
  assessment and, 24*t*
  cognitive restructuring, 7, 403
  focus of intervention and, 65–66
  integrative behavioral couple therapy and, 79–80
  older adult couples and, 456, 462, 464–465
  overview, 14
  posttraumatic stress disorder (PTSD) and, 535, 537, 545
  See also Change and change mechanisms
Cognitive fusion/defusion, 108, 116, 517
Cognitive therapy (CT), 53, 54
Cognitive-behavioral conjoint therapy for PTSD (CBCT PTSD)
  applicability and empirical support for, 545–546
  assessment and treatment planning and, 539–541
  case illustration, 546–551
  goal setting, 541–542
  mechanisms of change in, 544–545
  overview, 533–534, 551
  practice of, 536–544
  process and technical aspects of, 542–544
  role of therapist and, 538–539, 542–543
  structure of, 536–538
  See also Posttraumatic stress disorder (PTSD)
Cognitive-behavioral couple therapy (CBCT)
  adapting to address cultural and diversity issues, 68–69
  aggression and, 392, 394–395
  applicability and empirical support for, 72–73
  assessment and, 59–61
  case illustration, 73–76
  collaborative therapists and, 17
  depression and, 577
  evolution of couple therapies, 7
  focus of intervention and, 14, 62–67, 64*t*
  goal setting, 61–62
  healthy versus distressed relationships, 54–56
  infidelity and, 414, 416–424
  mechanisms of change in, 71–72
  overview, 6, 53–54, 76, 340
  practice of, 56–71, 64*t*
  process and technical aspects of, 62–71, 64*t*
  psychopathology and physical health concerns and, 69–70
  role of therapist and, 10, 57–58, 66, 67, 71
  sex therapy and, 447, 448
  specific, complex relationship difficulties, 70–71
  structure of, 56–57
  therapeutic palette integrative approach and, 352
Cognitive-behavioral interpersonal theory (C-BIT) of PTSD, 534–535. *See also* Posttraumatic stress disorder (PTSD)
Cognitive-behavioral therapy, 6, 16, 61, 600
Cohesion, couple. *See* Couple cohesion
Cohort differences, 455*f*, 458–459, 466–467, 468–469
Collaboration with medical providers. *See* Health care professionals, collaboration with
Collaborative processes
  aggression and, 404
  assessment and, 22
  cognitive-behavioral conjoint therapy for PTSD, 537
  cognitive-behavioral couple therapy and, 58, 61, 62
  divorce and, 476
  divorce therapy and, 478, 483–484
  integrating digital couple interventions into couple therapy and, 668
  intergenerational couple therapy and, 205–206
  listen–select–build process and, 251–252
  narrative couple therapy and, 230–231
  overview, 17, 131, 180*t*
  sex therapy and, 438, 446
  socioculturally attuned couple therapy and, 270, 271*t*, 273–274
  stepfamily couples and, 502
  therapeutic palette integrative approach and, 346
Collateral assessment data, 27, 601–602. *See also* Assessment
Collectivist cultures, 201, 269–270, 394. *See also* Cultural factors
Co-mentalizing, 180, 187. *See also* Mentalizing
Commitment
  acceptance and commitment couple therapy and, 112, 114
  alcohol behavioral couple therapy and, 560
  cognitive-behavioral conjoint therapy for PTSD, 538
  depression and anxiety and, 580
  divorce and, 477
  infidelity and, 425
  narrative couple therapy and, 236
  queer couples and, 517
  relationship education programs and, 640–641, 643–644, 649
Committed action, 109, 112, 117–118
Common factors in couple and family therapy, 300–309, 404–405
  applicability and empirical support and, 310–311
  case illustration, 311–315
  extratherapeutic and client factors, 304–305
  healthy versus distressed relationships and, 299–300
  history of, 295–298
  hope and expectancy and, 302–303
  mechanisms of change in, 309–310
  overview, 295, 298–299, 307–309, 315
  therapeutic alliance and, 301–302
  therapist factors and, 304–307, 311

Communication and interpersonal construct domain, 23–26, 24*t*–25*t*. *See also* Interpersonal communication skills
Communication patterns and skills
  aggression and, 392
  alcohol behavioral couple therapy and, 560
  assessment and treatment planning and, 24*t*, 30–31, 33
  cognitive-behavioral conjoint therapy for PTSD, 540, 541
  cognitive-behavioral couple therapy and, 56
  depression and anxiety and, 579
  emotionally focused couple therapy and, 128
  Gottman method and, 370
  integrative behavioral couple therapy and, 83
  medical issues and, 618–619
  mentalization-based couple therapy and, 187
  narrative couple therapy and, 236
  posttraumatic stress disorder (PTSD) and, 535
  See also Communication skills training
Communication Patterns Questionnaire—Constructive Communication (CPQ-CC), 33
Communication skills training
  acceptance and commitment couple therapy and, 115
  aggression and, 394, 400, 401, 402, 403, 404, 406
  alcohol behavioral couple therapy and, 557, 564, 568
  cognitive-behavioral conjoint therapy for PTSD, 536–537, 545
  cognitive-behavioral couple therapy and, 63–64, 64*t*, 70
  depression or anxiety and, 577, 584–585
  divorce therapy and, 481–482
  integrative behavioral couple therapy and, 83, 94
  medical issues and, 629–630
  older adult couples and, 457–458
  overview, 6
  relationship education programs and, 640, 642
  telemental health and, 661–662
  therapeutic palette integrative approach and, 352, 354
  See also Communication patterns and skills; Skills-based interventions and training
Community and cultural systems, 23–26, 24*t*–25*t*, 55, 325, 627–628, 645. *See also* Cultural factors
Comorbidity, 557, 565, 576–577, 596, 597, 602
Compassion, 90, 205, 211, 496, 497–498
Complex stepfamily, 493. *See also* Stepfamily couples
Conceptual model, 23–26, 24*t*–25*t*
Concurrent sessions, 155–156, 157–158. *See also* Individual sessions
Conduct disorder (CD), 596, 606. *See also* Disruptive behavior disorders parenting concerns
Confidentiality
  divorce therapy and, 479–480
  exceptions to, 687–688
  individual sessions and, 57, 61, 86–87
  infidelity and, 416–417
  overview, 681–684
  telehealth and, 658–659, 671
  before therapy begins, 685
Conflict management and recovery
  acceptance and commitment couple therapy and, 107, 111, 115
  aggression and, 393, 394, 403, 406
  alcohol behavioral couple therapy and, 560
  attention-deficit/hyperactivity disorder (ADHD) and, 598
  depression or anxiety and, 578, 585
  divorce therapy and, 473, 479, 484–486
  Gottman method and, 364, 365, 367–372, 380
  medical issues and, 621
  mentalization-based couple therapy and, 180*t*
  object relations couple therapy and, 169–171
  older adult couples and, 457–458
  posttraumatic stress disorder (PTSD) and, 535
  relationship education programs and, 640, 642, 643–644, 648
  telemental health and, 661–662
  therapeutic palette integrative approach and, 350–351
Conflict Tactics Scales (CTS; CTS2), 33, 112, 397, 545, 560
Conjoint Cognitive-Behavioral Treatment for Partner Aggression program (CCBTPA)
  applicability and empirical support for, 404–406
  assessment and treatment planning and, 396–398
  case illustration, 406–409
  goal setting, 398–399
  mechanisms of change in, 404
  overview, 393, 409–410
  practice of, 395–404
  process and technical aspects of, 399–404
  role of therapist and, 395–396
  sequencing of interventions implemented in, 402–403
Conjoint sessions, 155–156, 157–158, 179–180, 204–205, 416, 462
Conjoint therapy
  aggression and, 392–393, 395
  assessment and, 8–9
  differences across approaches and, 12
  ethical considerations and, 678
  integrative behavioral couple therapy and, 82
  integrative systemic therapy and, 323–324
  mentalization-based couple therapy and, 180*t*
  overview, 7

Conjoint therapy (*continued*)
  transitions to and from couple therapy and, 685–687
  violence and, 88–89
  whom to include in the couple therapy and, 9–10
Connection
  emotionally focused couple therapy and, 129, 137–138
  Gottman method and, 365, 373–374, 377–378
  infidelity and, 423
  intergenerational couple therapy and, 208
  overview, 7
  rituals of, 378–379
  stepfamily couples and, 494–495, 504
Consensual nonmonogamy, 519–522, 525–526. *See also* Infidelity
Consent process, 678–681, 680*t*. *See also* Informed consent
Constraints, 319–320, 476
Consultant role, 395–396, 558, 623. *See also* Therapist
Contempt, 343, 364, 370
Content validity, 36
Contextual adult lifespan theory for adapting psychotherapy (CALTAP), 455–466, 455*f*, 459–462, 469. *See also* Older adult couples
Contextual factors
  acceptance and commitment couple therapy and, 109
  ADHD and disruptive behavior disorders parenting concerns and, 598
  cognitive-behavioral couple therapy and, 61
  contextual adult lifespan theory for adapting psychotherapy (CALTAP) and, 455*f*
  contextual therapy, 8, 200, 201, 205–206. *See also* Intergenerational couple therapy
  emotionally focused couple therapy and, 128
  infidelity and, 415–416
  integrative behavioral couple therapy and, 81–82
  intergenerational couple therapy and, 206
  intergenerational therapy and, 199–200
  socioculturally attuned couple therapy and, 271*t*, 279*f*, 281–283
  See also External circumstances
Control
  acceptance and commitment couple therapy and, 107–108, 115–116
  aggression and, 394, 398
  cognitive-behavioral conjoint therapy for PTSD, 537
  medical issues and, 619
  object relations couple therapy and, 157–158
  socioculturally attuned couple therapy and, 284–285
Conversing, 324, 375. *See also* Therapeutic conversations
Co-parenting
  divorce therapy and, 479
  overview, 12, 18
  queer couples and, 518–519
  relationship education programs and, 649
  stepfamily couples and, 498–500, 499*f*, 501–502, 506
  See also ADHD parenting concerns; Children; Disruptive behavior disorders parenting concerns; Divorce; Parenting concerns; Stepfamily couples
Coping Questionnaire, 560
Coping strategies and functioning
  aggression and, 392, 394
  alcohol behavioral couple therapy and, 554, 560–561, 562–564
  common factors in couple and family therapy and, 304
  depression and anxiety and, 579–580
  healthy versus distressed relationships and, 55
  infidelity and, 420–424
  medical issues and, 619–621, 632
  older adult couples and, 456
  therapeutic palette integrative approach and, 342
Co-researchers, 231–232, 243
Cost-effectiveness guideline, 330, 331*t*
Co-therapy teams, 438, 462, 623, 645
Countertransference, 159–160, 163, 172, 205
Couple cohesion, 114–116, 579–580, 582–583
Couple discord model of depression, 577–578, 591. *See also* Couple therapy for anxiety or depression; Depression
Couple HOPES program, 667
Couple Questionnaire, 86*t*, 87
Couple therapy for anxiety or depression
  applicability and empirical support for, 587–589
  assessment and treatment planning and, 580–582
  case illustration, 589–591
  goal setting, 582
  mechanisms of change in, 586–587
  overview, 577, 591
  practice of, 580–586
  process and technical aspects of, 582–586
  role of therapist and, 580
  structure of, 580
  See also Anxiety; Depression; Family-focused therapy for anxiety disorders (FFT-AD)
Couple therapy in general, 3–11, 15–19
Couples Satisfaction Indexes (CSI; CSI-4; CSI-32), 86*t*, 87, 88, 112, 397, 540
Couples Together Against Violence (CTAV) program, 382
Court involvement. *See* Judicial system involvement
COVID-19 pandemic
  aggression and, 396–397
  Gottman method and, 381
  integrative behavioral couple therapy and, 82
  sex therapy and, 448
  telehealth and, 15–16, 622, 642, 656, 658, 663, 670, 692–693
Creative Relational Movement approach, 349–350
Creativity, 347, 350, 359

Criminal behaviors, 435*n*
Crisis, 349, 350–351, 417
Criticism
  depression or anxiety and, 578–579, 580, 584, 585, 588–589
  Gottman method and, 364, 369–370
  integrative behavioral couple therapy and, 81
  medical issues and, 629
  object relations couple therapy and, 151–152
  therapeutic palette integrative approach and, 343
Criticize–pursue patterns, 130
Cultural factors
  aggression and, 394, 398
  alcohol behavioral couple therapy and, 556–557, 566
  applicability and empirical support for, 261–262
  approaches to couple therapy and, 17
  assessment and, 27
  Bowen therapy and, 200
  cognitive-behavioral couple therapy and, 54, 56, 59, 68–69
  contextual adult lifespan theory for adapting psychotherapy (CALTAP) and, 455*f*
  divorce and, 474–475
  emotionally focused couple therapy and, 139
  infidelity and, 415, 419
  integrative systemic therapy and, 327
  intergenerational therapy and, 201
  intersectional framework and, 513–516
  narrative couple therapy and, 232
  object relations couple therapy and, 158
  older adult couples and, 459, 468–469
  overview, 8, 694–695
  relationship education and, 640, 650–651
  sexual problems and, 435, 437, 443*t*
  solution-focused couple therapy and, 265
  stepfamily couples and, 504–508
  therapeutic palette integrative approach and, 342, 343, 351, 353
  therapist competence and, 68–69, 694–696
  See also Identity-related factors; Socioculturally attuned family therapy (SCAFT)
Curative factors, 186–188, 309–310, 487. *See also* Change and change mechanisms
Curiosity, 185, 205, 252, 351, 501
Custody arrangements, 474–475, 479–480, 484–485, 501–502. *See also* Divorce; Parenting concerns
Cyber-infidelity, 413, 415. *See also* Infidelity

D

Decision-making or problem-solving conversations
  cognitive-behavioral couple therapy and, 63, 64
  depression or anxiety and, 585
  integrating digital couple interventions into couple therapy and, 668–669
  integrative systemic therapy and, 322, 322*f*, 332
  See also Communication skills training
DEEP analysis, 84–85, 88, 89–90, 98–99, 668–669, 672. *See also* Integrative behavioral couple therapy (IBCT)
"Deepening" step, 132, 146–147
Deescalation, 30, 132, 156, 182. *See also* Conflict management and recovery
Defensiveness, 215, 343, 364, 369–370, 373, 422
Defusion, cognitive, 108, 112, 116
Dementias, 462, 464–465, 467, 469
Depression
  acceptance and commitment couple therapy and, 119
  aggression and, 394
  alcohol use disorder (AUD) and, 557
  applicability and empirical support for couple therapy for, 587–588
  assessment and, 33–34
  case illustration, 589–591
  cognitive-behavioral conjoint therapy for PTSD, 540
  cognitive-behavioral couple therapy and, 69–70, 73
  core understandings about, 577–580
  depressive disorders, 576
  emotionally focused couple therapy and, 138–139, 140
  infidelity and, 413, 414, 420, 421, 426
  mechanisms of change in the treatment of, 586–587
  mentalization-based therapy (MBT) and, 175
  overview, 53, 576–577, 591
  practice of couple therapy for, 580–586
  queer couples and, 513
  See also Couple therapy for anxiety or depression; Mental health
Desensitization, 93
Desire, sexual, 434, 435. *See also* Sexual problems
Detachment, 14, 130
Devaluation, 584
Developmental factors
  assessment and, 23–26, 24*t*–25*t*
  divorce and, 474
  integrative systemic therapy and, 326
  intergenerational couple therapy and, 207
  object relations theory and, 151, 153
  older adult couples and, 455–458
  sexual problems and, 435
Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), 435, 464, 595, 602
Differences between partners. *See* Individual differences
Differentiation, 200, 211–212, 216–217, 218

Digital couple interventions (DCIs), 664–673, 692–693. *See also* Technology; Telehealth; Telemental health (TMH)
Direct or deliberate change strategies, 90, 92–94. *See also* Change and change mechanisms
Directiveness, 11, 341–342, 359
Disability, 268, 461, 462–465, 467, 469, 621–622. *See also* Identity-related factors; Medical issues
Discernment counseling, 476, 478, 487–488. *See also* Divorce therapy
Disclosures
  aggression and, 403
  boundary issues and, 691
  cognitive-behavioral conjoint therapy for PTSD, 543
  depression and anxiety and, 579–580
  emotionally focused couple therapy and, 134
  empathic joining and, 90–91
  ethical considerations and, 683
  infidelity and, 419
  therapeutic palette integrative approach and, 347
Discrimination
  aggression and, 394, 398
  cognitive-behavioral conjoint therapy for PTSD, 540
  emotionally focused couple therapy and, 139
  intergenerational therapy and, 201
  older adult couples and, 460–461
  queer couples and, 513
  socioculturally attuned couple therapy and, 284–285
Disengagement, 30, 31, 130, 370, 476–477, 482. *See also* Stonewalling patterns
Disorder-focused interventions, 16, 69, 70. *See also individual interventions*
Disruptive Behavior Disorder Rating Scale, 602
Disruptive behavior disorders parenting concerns
  applicability and empirical support for treatment with, 606–607
  assessment and treatment planning and, 601–603
  case illustration, 607–611
  core understandings about, 597–598
  goal setting, 603–604
  mechanisms of change and, 606
  overview, 595–597, 611–612
  practice of couple therapy for, 598–606
  process and technical aspects of working with, 604–606
  role of therapist and, 600–601
  structure of, 599–600
  See also Attention-deficit/hyperactivity disorder (ADHD); Behavioral parent training (BPT); Parenting concerns
Distressed relationships. *See* Relationship functioning
Diversity, 17, 68–69, 138–139, 201, 566. *See also* Cultural factors; Identity-related factors
Divorce
  assessing the inclination for, 363–364, 381, 476–477
  case illustration, 487–489
  cognitive-behavioral conjoint therapy for PTSD, 545–546
  cohort differences and, 458
  core understandings about, 473–475
  depression or anxiety and, 587
  emotionally focused couple therapy and, 142
  ethical considerations and, 681, 689–690
  infidelity and, 413, 423–424
  integrative behavioral couple therapy and, 89–90
  older adult couples and, 454
  overview, 3, 18, 472–473, 489
  practice of working with in couple therapy, 475–487
  role of therapist and, 477–478
  sex therapy and, 444
  stepfamily couples and, 501–502
  See also Co-parenting; Divorce therapy; Stepfamily couples
Divorce therapy
  applicability and empirical support for, 487
  case illustration, 487–489
  goal setting, 478–479
  judicial system involvement, 479–480, 484–486
  mechanisms of change in, 487
  overview, 477–487, 489
  process and technical aspects of, 477–484
  role of therapist and, 480, 487
  therapeutic alliance and, 480
  therapy contract for, 479–480, 485
  See also Divorce
Domestic violence. *See* Intimate partner violence (IPV); Violence
Down-regulating negative affect, 365, 367–371
Dreams, 365, 370–371, 378–379
Drinker Inventory of Consequences, 560
Drinking problems. *See* Alcohol use; Substance abuse
Dyadic Adjustment Scale (DAS), 32, 560
Dyadic processes, 23–26, 109–110, 399–400, 620. *See also* Coping strategies and functioning
Dyadic Splitting Scale, 173
Dysphoria, 523–524, 527–528

E

Eating disorders, 175, 690
Ecological perspective, 53, 54
Education, relationship. *See* Relationship education
Either–or position, 185, 497
Emotion coaching interventions, 363, 374–375, 376–378
Emotion regulation
  aggression and, 392, 394, 401–402, 404
  cognitive-behavioral conjoint therapy for PTSD, 536
  cognitive-behavioral couple therapy and, 73
  healthy versus distressed relationships and, 203

  infidelity and, 417, 421
  intergenerational couple therapy and, 209
  interventions focusing on in CBCT, 66–67
  medical issues and, 630–631
  older adult couples and, 456
  relationship education programs and, 640–641
  tolerance building and, 93–94
Emotional factors
  acceptance and commitment couple therapy and, 107, 115
  cognitive-behavioral couple therapy and, 55–56
  emotionally focused couple therapy and, 134–135
  Gottman method and, 366, 373–374, 376–378
  integrative systemic therapy and, 326–327
  interventions focusing on in CBCT, 66–67
  medical issues and, 620
  older adult couples and, 462
  overview, 14
  posttraumatic stress disorder (PTSD) and, 536
  socioculturally attuned couple therapy and, 269
  therapeutic palette integrative approach and, 344
Emotional focused therapy, 6
Emotional intelligence, 172
Emotional sensitivities, 84–85
Emotional-experiential processes, 217
Emotionally focused couple therapy (EFCT)
  applicability and empirical support for, 138–142
  assessment and, 36–37, 133–134
  becoming an EFT therapist, 142–143
  case illustration, 143–147
  emotional expression and, 67
  evolution of couple therapies, 7–8
  focus of intervention and, 14
  Gottman method and, 367
  healthy versus distressed relationships and, 130–131
  individual disorders and, 16
  mechanisms of change in, 137–138
  medical issues and, 628
  overview, 127–130, 148, 340
  practice of, 131–137
  process and technical aspects of, 134–137
  relationship education programs and, 642
  role of therapist and, 133
  sex therapy and, 447
  stages and steps of, 132–133
  structure of, 131–132
  termination and, 136–137. *See also* Emotionally focused therapy (EFT)
Emotionally focused therapy (EFT)
  aggression and, 392
  assessment and, 33, 36–37
  common factors in couple and family therapy and, 299–300, 304, 307, 310
  evolution of couple therapies, 7–8
  overview, 9, 127–130
  See also Emotionally focused couple therapy (EFCT)
Emotion-focused couple therapy, 8, 352, 367, 517
Empathy
  ADHD and disruptive behavior disorders parenting concerns and, 600–601
  aggression and, 404
  alcohol behavioral couple therapy and, 558–559
  common factors in couple and family therapy and, 303, 305
  divorce therapy and, 477, 480, 487
  empathic conjecture, 132, 135
  ethical considerations and, 681
  Gottman method and, 370
  infidelity and, 420, 422, 423, 424
  integrative behavioral couple therapy and, 83
  intergenerational couple therapy and, 207, 208–209, 212
  joining, 14, 90–91, 92, 94, 99–100
  mentalization-based couple therapy and, 184–185, 188
  object relations couple therapy and, 171
  overview, 7
  sex therapy and, 448
  solution-focused couple therapy and, 261
  stepfamily couples and, 494–495, 497–498, 504
  vulnerability and, 202–203
Enactments, 132, 352
End-of-life decisions, 632
Engagement
  assessment and, 31
  case illustration, 146–147
  common factors in couple and family therapy and, 309
  emotionally focused couple therapy and, 129–130, 137–138
  Gottman method and, 380
  object relations couple therapy and, 160–161
  overview, 7
  socioculturally attuned couple therapy and, 275
Enhanced Gottman Relationship Checkup, 181
Enhancement programs. *See* Relationship education
Environmental factors, 55, 304, 366–367, 513. *See also* External circumstances
Envision, 274, 276, 279*f*, 283–284
Epistemic trust, 176–177, 186, 187
ePREP program
  future directions and, 671–672
  integration of into treatment, 665, 666, 669–670
  overview, 642, 643, 653
  See also Prevention and Relationship Education Program (PREP)
Equity, 267, 268, 269–270
Erectile dysfunction (ED), 434, 435, 436–437. *See also* Sexual problems
Escalation, 30, 81, 156, 364. *See also* Conflict management and recovery
Ethical considerations
  aggression and, 399, 405
  boundary issues, 690–692
  confidentiality and private information, 681–684, 685, 687–688

Ethical considerations (*continued*)
  consent process, 678–681, 680*t*
  contraindications for couple therapy, 688–690
  infidelity and, 418
  integrating digital couple interventions into couple therapy and, 670–671
  medical issues and, 632
  overview, 10–11, 677–678, 696
  relationship education programs and, 648
  telehealth and, 658–659, 692–693
  therapist competence and, 68–69, 693–696
  transitions to and from couple therapy and, 685–687
Ethnicity
  aggression and, 394, 398
  alcohol behavioral couple therapy and, 566
  approaches to couple therapy and, 17
  cognitive-behavioral conjoint therapy for PTSD, 540
  emotionally focused couple therapy and, 139
  flow of information outside of therapy, 684–685
  intersectional framework and, 513–516
  narrative couple therapy and, 232
  object relations couple therapy and, 154, 158
  queer couples and, 513
  relationship education and, 640, 650–651
  socioculturally attuned couple therapy and, 268
  therapeutic palette integrative approach and, 351
  therapist competence and, 694–696
  See also Identity-related factors
Expectations
  assessment and, 23
  common factors in couple and family therapy and, 302–303
  depression or anxiety and, 582
  divorce and, 474, 481–482
  infidelity and, 414, 415
  intergenerational couple therapy and, 215
  object relations couple therapy and, 154, 155, 159
  older adult couples and, 458
  relationship education programs and, 640–641
  socioculturally attuned couple therapy and, 269
  stepfamily couples and, 502–503
  telemental health and, 662
Experiences in Close Relationship Scale (ECR-S), 33
Experiencing, 137–138
Experiential acceptance, 108. *See also* Acceptance
Experiential approaches, 8, 127–129, 447, 539
Experiential avoidance, 108, 112, 119. *See also* Avoidance
Exposure techniques
  cognitive-behavioral conjoint therapy for PTSD, 537
  cognitive-behavioral couple therapy and, 69, 70
  couple therapy for anxiety and, 577
  depression or anxiety and, 585, 586
  posttraumatic stress disorder (PTSD) and, 534
Expressed emotion (EE), 578–579, 588–589
Expression of emotions
  depression and anxiety and, 579–580
  depression or anxiety and, 583
  emotionally focused couple therapy and, 131
  Gottman method and, 376–378
  infidelity and, 420–421
  interventions focusing on in CBCT, 66–67
  posttraumatic stress disorder (PTSD) and, 535
  therapeutic palette integrative approach and, 344
  See also Reactivity
Extended family
  alcohol use and, 556–557
  assessment and, 23–26, 24*t*–25*t*
  divorce therapy and, 477, 484
  healthy versus distressed relationships and, 55
  socioculturally attuned couple therapy and, 273
  See also Family-of-origin history
External circumstances, 80–81, 84–85, 343–344, 420, 513. *See also* Contextual factors; Environmental factors
Externalizing conversations, 234–235, 354
Extramarital affairs. *See* Infidelity

F

Family factors, 56
Family systems approaches, 11, 23–26, 24*t*–25*t*, 127, 554, 616–618, 617*f*
Family therapy, 11, 175, 483–484, 686–687
Family-focused therapy for anxiety disorders (FFT-AD), 577, 585–586. *See also* Couple therapy for anxiety or depression
Family-of-origin
  acceptance and commitment couple therapy and, 112
  aggression and, 394, 397
  alcohol use and, 556–557
  attention-deficit/hyperactivity disorder (ADHD) and, 597–598
  integrative behavioral couple therapy and, 87
  integrative systemic therapy and, 327, 329
  intergenerational couple therapy and, 204, 205, 207, 212–217
  intergenerational therapy and, 199–200
  object relations couple therapy and, 153, 158, 162–163
  relationship education programs and, 642
  socioculturally attuned couple therapy and, 273
  stepfamily couples and, 493–494, 496, 498, 500, 501, 502

- therapeutic palette integrative approach and, 353
- *See also* Extended family; Histories

Family-of-origin history, 323

Feedback
- acceptance and commitment couple therapy and, 112–113
- alcohol behavioral couple therapy and, 562–563
- assessment and, 29
- case illustration, 43–44
- cognitive-behavioral couple therapy and, 57–58, 62
- depression and anxiety and, 580
- depression or anxiety and, 584
- integrative behavioral couple therapy and, 87–88
- integrative systemic therapy and, 322, 324–325
- intergenerational couple therapy and, 205–206
- overview, 7
- *See also* Therapeutic conversations

Feminist perspectives
- aggression and, 391–392, 394
- emotionally focused couple therapy and, 129–130
- integrative systemic therapy and, 326
- intersectional framework and, 514
- narrative couple therapy and, 227
- overview, 8
- socio-emotional relationship therapy (SERT) and, 268

Fight-or-flight response, 203, 367, 536

Financial factors, 342, 642, 649, 664, 673. *See also* Poverty; Socioeconomic status

Finding meaning, 422–423

Flexibility, 112, 203, 343, 537, 580. *See also* Psychological flexibility

Flooding, 155, 173, 370

Forgiveness, 203, 215–216, 414, 423–424

Formulation, case. *See* Case formulation

Four Horsemen of the Apocalypse factors, 364, 369. *See also* Contempt; Criticism; Defensiveness; Stonewalling patterns

Four-session-evaluation option, 323–324, 441

Frailty, physical, 462–464, 467

Frequency and Acceptability of Partner Behavior Inventory (FAPBI), 33

Fusion, cognitive, 108, 112, 116, 517

Future, role of
- acceptance and commitment couple therapy and, 109
- intergenerational therapy and, 201–202
- mentalization-based couple therapy and, 180*t*
- narrative couple therapy and, 230
- overview, 14–15
- socioculturally attuned couple therapy and, 268
- solution-focused couple therapy and, 261
- therapeutic palette integrative approach and, 344
- *See also* Temporal framework

G

Gay male couples, 512–513. *See also* Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples; Queer couples

Gender
- aggression and, 391–392, 394, 398, 405–406
- approaches to couple therapy and, 17
- cognitive-behavioral conjoint therapy for PTSD, 540
- emotionally focused couple therapy and, 129–130, 138–139
- gender fluidity, 438, 512–513
- gender role socialization and, 516–518
- group therapy/support groups and, 392, 405–406
- inclusive language and, 512–513
- infidelity and, 415
- integrative systemic therapy and, 326
- levels of intervention and, 13
- narrative couple therapy and, 232, 234
- object relations couple therapy and, 154, 158
- overview, 8, 18
- queer couples and, 523–524, 527–528
- sex therapy and, 438
- socioculturally attuned couple therapy and, 268, 272, 285–286
- stepfamily couples and, 497
- therapeutic palette integrative approach and, 343, 351
- therapist competence and, 694–696
- *See also* Identity-related factors

Generalized anxiety disorder (GAD), 576, 577, 578, 579, 588–589. *See also* Anxiety disorders

Genograms, 33, 200, 207, 397, 503, 504, 626

Gerontology, 458–459. *See also* Older adult couples

Gestalt approach, 127

Gifts from clients, 691–692

Goal setting
- acceptance and commitment couple therapy and, 109–110, 111–114, 113*f*
- ADHD and disruptive behavior disorders parenting concerns and, 603–604
- aggression and, 398–399
- alcohol behavioral couple therapy and, 561
- cognitive-behavioral conjoint therapy for PTSD, 541–542
- depression or anxiety and, 582
- divorce therapy and, 478–479
- emotionally focused couple therapy and, 133–134
- Gottman method and, 380–381
- infidelity and, 420
- integrative systemic therapy and, 324
- intergenerational couple therapy and, 208
- medical issues and, 627–628
- mentalization-based couple therapy and, 181–182

Goal setting (*continued*)
  narrative couple therapy and, 232–233
  object relations couple therapy and, 160–161
  sex therapy and, 442–444
  socioculturally attuned couple therapy and, 278–279
  solution-focused couple therapy and, 254–255, 256–257
  therapeutic palette integrative approach and, 349
Goals of treatment
  acceptance and commitment couple therapy and, 108, 109–110
  aggression and, 402, 404
  alcohol behavioral couple therapy and, 560
  assessment and, 22, 29–30
  cognitive-behavioral conjoint therapy for PTSD, 539, 542
  cognitive-behavioral couple therapy and, 61–62
  differences across approaches and, 11
  divorce therapy and, 485
  ethical considerations and, 679–680, 680*t*
  Gottman method and, 367–380
  integrative approaches and, 88, 89–90, 340–341
  intergenerational couple therapy and, 208
  intermediate versus ultimate goals, 15
  maintaining gains, 18–19
  narrative couple therapy and, 235
  older adults couples and, 467
  solution-focused couple therapy and, 256–257
Gottman method
  acceptance and, 17
  applicability and empirical support for, 382–383
  assessment and, 33, 363–364, 380–381
  case illustration, 383–384
  collaborative therapists and, 17
  common factors in couple and family therapy and, 300
  convergence of methods and, 6
  healthy versus distressed relationships and, 365
  integrating digital couple interventions into couple therapy and, 668
  mentalization-based couple therapy and, 179
  overview, 362–365, 366–367, 384
  practice of, 366–381
  process and technical aspects of, 367–380
  role of therapist and, 10
  sex therapy and, 447
  structure of, 367
  technology use and, 16
  therapeutic palette integrative approach and, 346
Gratitude, 216, 583
Grief, 463, 465–466, 619
Group therapy, 297, 392, 405–406, 462–463, 477. *See also* Relationship education
Guilt, 81, 203, 215–216, 629, 632

H
Happy couples. *See* Healthy vs. distressed relationships; Relationship functioning
Hard disclosures, 90–91
Health care professionals, collaboration with, 622–624, 628. *See also* Medical issues
Health factors. *See* Medical issues; Mental health; Physical health problems
Health Insurance Portability and Accountability Act (HIPAA), 660, 671, 692
Healthy guilt. *See* Guilt
Healthy vs. distressed relationships
  acceptance and commitment couple therapy and, 105–108
  aggression and, 394
  cognitive-behavioral couple therapy and, 54–56
  common factors and, 299–300
  emotionally focused couple therapy and, 130–131
  Gottman method and, 362, 365
  integrative behavioral couple therapy and, 80–82
  integrative systemic therapy and, 319
  intergenerational couple therapy and, 202–204
  medical issues and, 616–622, 617*f*
  mentalization-based couple therapy and, 178–179
  narrative couple therapy and, 228–229
  object relations couple therapy and, 154–155
  socioculturally attuned couple therapy and, 269–273, 271*t*, 272*f*
  therapeutic palette integrative approach and, 342–344
  See also Relationship functioning
Heightening, 131–132, 134–135
Heterosexist bias, 13, 232, 513
Hierarchy, 213, 269–270
Hindsight bias, 535. *See also* Bias
Histories
  acceptance and commitment couple therapy and, 111–112
  ADHD and disruptive behavior disorders parenting concerns and, 601
  aggression and, 399
  assessment and, 27–29
  CBCT assessment and, 59–60
  cognitive-behavioral conjoint therapy for PTSD, 538, 539–540
  divorce therapy and, 483
  Gottman method and, 380–381
  integrative behavioral couple therapy and, 85–86, 87
  integrative systemic therapy and, 327–328
  medical issues and, 625–626
  object relations couple therapy and, 158, 162–163
  overview, 14–15
  sexual problems and, 435, 440–441
  socioculturally attuned couple therapy and, 277
  solution-focused couple therapy and, 254–255
  See also Temporal framework
Hold Me Tight (HMT) program, 142, 640, 642, 665, 670, 672
Homeostasis, 320, 554

Homework assignments
  ADHD and disruptive behavior disorders parenting concerns and, 600, 601, 604
  aggression and, 403, 404
  alcohol behavioral couple therapy and, 557, 561–562, 567
  cognitive-behavioral conjoint therapy for PTSD, 539, 544
  cognitive-behavioral couple therapy and, 56–57
  depression or anxiety and, 580, 582, 584–585
  digital couple interventions as, 665
  integrating digital couple interventions into couple therapy and, 669
  intergenerational couple therapy and, 208
  sex therapy and, 438–439, 444–446
Homicidality, 545, 687–688
Homophobia, 201, 513
Hope
  alcohol behavioral couple therapy and, 559
  cognitive-behavioral conjoint therapy for PTSD, 539
  common factors in couple and family therapy and, 302–303, 309–310
  hopelessness, 160–161, 399
  narrative couple therapy and, 236
  overview, 7
  solution-focused couple therapy and, 261
Hostility, 29–30, 588–589. *See also* Criticism
Humor, 187–188
Hypothesizing, 325–327, 326*f*. *See also* Feedback

I

Identity-related factors
  aggression and, 398
  alcohol behavioral couple therapy and, 566
  cognitive-behavioral conjoint therapy for PTSD, 540
  cognitive-behavioral couple therapy and, 56, 59, 68–69
  emotionally focused couple therapy and, 138–139
  intergenerational therapy and, 201
  intersectional framework and, 513–516
  narrative couple therapy and, 232, 238–239, 240–241
  object relations couple therapy and, 158
  queer couples and, 513–516, 519, 523–524
  relationship education programs and, 649–651
  socioculturally attuned couple therapy and, 268, 269, 273, 277
  therapeutic palette integrative approach and, 351
  therapist competence and, 694–696
  trans people and, 523–524
  unified detachment and, 91–92
  See also Ability/disability; Age; Cultural factors; Ethnicity; Gender; Race; Religion; Sexual orientation; Sexuality; Socioeconomic status
I–It way of being, 306
Imagery, 347, 534
Immigration, 201, 214, 514
Impairment Rating Scale, 602
In vivo exposure, 534, 537. *See also* Exposure techniques
Individual differences
  acceptance and tolerance of, 80
  DEEP analysis and, 84–85
  intergenerational couple therapy and, 209
  object relations couple therapy and, 169–171
  overview, 8, 22
  self-report methods of assessment and, 32
  stepfamily couples and, 501, 504–508
  unified detachment and, 91–92
Individual level of functioning and needs
  aggression and, 398, 400
  alcohol use and, 556–557
  assessment and, 23–26, 24*t*–25*t*, 27–28, 33–34
  cognitive-behavioral conjoint therapy for PTSD, 545
  cognitive-behavioral couple therapy and, 54–55
  digital couple interventions and, 665
  divorce therapy and, 483
  emotionally focused couple therapy and, 132–133
  Gottman method and, 365
  infidelity and, 414
  intergenerational couple therapy and, 204, 207, 212
  levels of intervention and, 13
  overview, 16, 53
  sex therapy and, 438–439
  socioculturally attuned couple therapy and, 269
  See also Anxiety; Depression; Mental health
Individual sessions
  acceptance and commitment couple therapy and, 112
  aggression and, 397–398
  alcohol behavioral couple therapy and, 557
  for assessment purposes, 27, 60–61, 86–87, 112, 158, 323–324, 539–541
  cognitive-behavioral conjoint therapy for PTSD, 538, 539–541
  cognitive-behavioral couple therapy and, 57, 60–61
  confidentiality and private information and, 681–682
  infidelity and, 416, 417, 423
  integrating digital couple interventions into couple therapy and, 668
  integration of digital couple interventions into treatment and, 665
  integrative behavioral couple therapy and, 86–87
  integrative systemic therapy and, 323–324, 330
  intergenerational couple therapy and, 204–205
  mentalization-based couple therapy and, 179, 181*t*
  object relations couple therapy and, 155–156, 158
  older adult couples and, 462
  sex therapy and, 440–441
  socioculturally attuned couple therapy and, 273
  telemental health and, 662

Individual sessions (*continued*)
  transitions to and from couple therapy and, 686
  See also Concurrent sessions; Individual therapy
Individual therapy
  cognitive-behavioral couple therapy and, 54, 57
  convergence of methods and, 6
  digital couple interventions and, 665
  ethical considerations and, 685–686, 690
  older adults couples and, 467
  overview, 11
  transitioning to following divorce therapy, 486–487
  See also Individual sessions
Infertility, 632
Infidelity
  alcohol behavioral couple therapy and, 557
  applicability and empirical support for treatment of, 425–426
  assessment and, 30, 418–420
  case illustration, 426–430
  cognitive-behavioral conjoint therapy for PTSD, 541–542, 546
  cognitive-behavioral couple therapy and, 71
  core understandings about, 415–416
  depression and anxiety and, 578
  depression or anxiety and, 584
  emotionally focused couple therapy and, 141–142
  ethical considerations and, 681–682, 683, 685, 688
  goal setting, 420
  intergenerational couple therapy and, 217–218
  mechanisms of change and, 424–425
  older adult couples and, 462
  overview, 53, 413–414, 430–431, 688–689
  practice of couple therapy for recovery from, 416–424
  process and technical aspects of treatment and, 420–424
  queer couples and, 520
  relationship education programs and, 643–644
  role of therapist and, 417–418, 425
  sex therapy and, 444
  structure of couple therapy and, 416–417
  See also Consensual nonmonogamy
Inflexibility, psychological, 104, 110, 112
Influence, 270, 272, 272*f*
Informed consent, 658–659, 671, 678–681, 680*t*
Insecure attachment, 130–131, 140, 299–300, 377, 392. *See also* Attachment
Insider–outsider relationships, 494–496, 497–498
Insight, 24*t*, 217, 447
Insight-oriented couple therapy (IOCT), 19, 71, 414, 416–424
Integration, 106, 132, 133, 665–671
Integrative approaches, 6–7, 142, 339–342, 484, 665–669. *See also* Gottman method; Integrative behavioral couple therapy (IBCT); Integrative systemic therapy (IST); Therapeutic palette integrative approach (TP)
Integrative behavioral couple therapy (IBCT)
  acceptance and, 17
  applicability and empirical support for, 95–97
  assessment and treatment planning and, 84–89, 86*t*
  case illustration, 97–101
  digital couple interventions and, 665–666, 672
  evolution of couple therapies, 7
  focus of intervention and, 14
  goal setting, 89–90
  healthy versus distressed relationships and, 80–82
  infidelity and, 426
  mechanisms of change in, 94–95
  overview, 79–80, 105
  parenting challenges and, 604–606
  practice of, 82–94, 86*t*
  process, techniques, and strategies of, 90–94
  role of therapist and, 10, 83–84, 85–86
  structure of, 82–83
Integrative problem-centered metaframeworks (IPCM) therapy. *See* Integrative systemic therapy (IST)
Integrative systemic therapy (IST)
  assessment and, 37, 323–324
  case illustration, 333–336
  convergence of methods and, 6
  goal setting, 324
  healthy versus distressed relationships and, 319
  mechanisms of change in, 332–333
  overview, 318, 337
  practice of, 319–332, 321*f*, 322*f*, 326*f*, 328*f*, 331*t*
  process and technical aspects of, 324–331, 326*f*, 328*f*, 331*t*
  role of therapist and, 322–323
  structure of, 319–322, 321*f*, 322*f*
  termination and, 331–332
  whom to include in the couple therapy and, 10
Intention, 187, 188, 326–327
Interaction patterns. *See* Patterns of interaction
Interactional positions, 127, 132–133, 135, 187, 207
Intercourse pain, 434, 435. *See also* Sexual problems
Intercultural couples, 139, 143–147. *See also* Cultural factors
Interdependence, 130, 269–270
Intergenerational approaches, 8, 9, 11, 33, 199–202, 270
Intergenerational couple therapy
  applicability and empirical support for, 217–218
  assessment and treatment planning and, 206–207
  case illustration, 218–222, 219*f*
  common factors in couple and family therapy and, 299
  goal setting, 208
  healthy versus distressed relationships and, 202–204
  mechanisms of change in, 217
  overview, 222
  practice of, 204–217

- process and technical aspects of, 208–217
- role of therapist and, 205–206
- structure of, 204–205

Intergenerational factors, 203, 271*t*, 556–557
Internalizing disorders, 261–262, 576–577. *See also* Anxiety; Depression
Internet-delivered treatment. *See* Online programs; Remote therapy; Telehealth
Interpersonal communication skills
- assessment and, 23–26, 24*t*–25*t*
- integrative systemic therapy and, 320
- stepfamily couples and, 495–496, 497–498, 499–500, 501, 503, 504
- *See also* Communication and interpersonal construct domain

Interpersonal factors
- alcohol use and, 555
- depression and anxiety and, 579–580
- guidelines and, 330, 331*t*
- integrative systemic therapy and, 320–321
- neurobiology and, 201, 203
- sex therapy and, 443*t*, 447
- stepfamily couples and, 493

Interrupting phase, 279, 279*f*, 281–283
Intersectional lens, 268, 504–508, 513–516, 519
Interventions
- aggression and, 399–404
- alcohol behavioral couple therapy and, 562–564
- assessment and, 29, 33
- cognitive-behavioral conjoint therapy for PTSD, 543–544
- cognitive-behavioral couple therapy and, 62–66, 64*t*
- common factors in couple and family therapy and, 299, 300, 307–309
- depression or anxiety and, 582
- divorce and, 477
- emotionally focused couple therapy and, 135–137
- Gottman method and, 365, 367–380
- infidelity and, 420–424
- integrative systemic therapy and, 331*t*
- intergenerational couple therapy and, 208–217
- levels and focus of, 13–14
- manualized versus improvisational approaches, 15
- mentalization-based couple therapy and, 184–186
- overview, 6, 9
- sex therapy and, 444–446
- socioculturally attuned couple therapy and, 274, 276
- solution-focused couple therapy and, 253–259, 265
- telemental health and, 660–663
- temporal framework and, 14–15
- therapeutic palette integrative approach and, 350–352, 353–354
- when to intervene, 259
- *See also* Techniques; Therapeutic strategies

Interview, clinical. *See* Assessment; Clinical interview
Intimacy
- acceptance and commitment couple therapy and, 107, 115
- assessment and, 31
- cognitive-behavioral conjoint therapy for PTSD, 538
- depression and anxiety and, 579–580
- emotionally focused couple therapy and, 130
- Gottman method and, 374–376
- medical issues and, 627
- mentalization-based couple therapy and, 180*t*
- object relations couple therapy and, 154, 159
- older adult couples and, 456–457
- overview, 10
- queer couples and, 517
- relationship education programs and, 640–641
- sexuality and, 18

Intimate partner violence (IPV)
- acceptance and commitment couple therapy and, 119
- alcohol behavioral couple therapy and, 557, 560, 565
- assessment and treatment planning and, 396–398
- cognitive-behavioral conjoint therapy for PTSD, 541
- depression or anxiety and, 578, 587
- divorce and, 477
- emotionally focused couple therapy and, 141
- ethical considerations and, 687–688, 689
- infidelity and, 413, 417
- integrative behavioral couple therapy and, 88–89
- narrative couple therapy and, 242–243
- object relations couple therapy and, 155–156, 158
- overview, 53, 391
- relationship education programs and, 647–648
- telemental health and, 659
- *See also* Aggression; Violence

Intimidating behavior, 157–158, 343
Isolation, 136, 159, 620
I–Thou way of being, 306

J

Joining, 14, 308, 353, 495–496, 497–498, 499–500
Jointly seeing to it (JSTIT), 186–187, 188
Judicial system involvement, 479–480, 484–486, 684, 690. *See also* Legal considerations

L

Language, 398, 512–513, 568
Last chance couples, 349, 354, 444, 545–546, 587, 689–690. *See also* Goals of treatment
Latinx couples, 506–507, 651. *See also* Cultural factors; Ethnicity; Race
Leadership, 275, 325
Learning, 267–268, 353–354, 539
Legal considerations, 663, 670–671, 684, 690. *See also* Judicial system involvement

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples
  approaches to couple therapy and, 17
  case illustration, 525–528
  divorce and, 472
  inclusive language and, 512–513
  overview, 8, 18, 528
  relationship education programs and, 648, 649–650
  role of therapist and, 524–525
  sex therapy and, 435, 438
  stepfamily couples and, 492, 505–506
  therapist competence and, 694–696
  See also Identity-related factors; Queer couples
Lesbian couples, 512–513. *See also* Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples; Queer couples
License jurisdiction, 670, 692–693
Life cycle, 18, 342, 363, 458–459. *See also* Transitions
Life goals, 379, 404
Limit setting, 214, 403, 560
Listening
  aggression and, 402–403
  alcohol behavioral couple therapy and, 558–559
  common factors in couple and family therapy and, 308
  divorce therapy and, 480
  infidelity and, 422
  listening skills, 63–64, 64*t*
  narrative couple therapy and, 233, 239–240
  overview, 7
  therapeutic palette integrative approach and, 353
  See also Communication skills training
Listen–select–build process, 251–252
Loss, 201, 214, 342, 496, 619
Love, 342–343, 365, 374
Loving Update meeting, 214–215, 218
Low sexual desire, 435

M
"The magic question," 210–211, 219–220, 257
Maintenance of change, 18–19, 564, 585
Major depressive disorder (MDD), 588. *See also* Depression
Managed care, 684
Marginalization
  aggression and, 398
  bisexuality and, 522–523
  cognitive-behavioral conjoint therapy for PTSD, 540
  emotionally focused couple therapy and, 128
  intersectional framework and, 513–516
  polyamory and, 521–522
  queer couples and, 513–516
Marital Satisfaction Inventories (MSI-R; MSI-B), 32, 33, 41, 42*f*, 43
Marital Status Inventory, 477
Meaning construction, 172, 327, 422–423, 619
Meaning/emotion metaframework, 327, 328–329
Mechanisms of change. *See* Change and change mechanisms
Mediation, 11, 477, 487. *See also* Divorce
Medical issues
  applicability and empirical support for couple therapy for, 632
  assessment and treatment planning and, 30, 625–627, 625*t*
  case illustrations, 618, 621–625, 626–628, 629, 630–631
  emotionally focused couple therapy and, 139
  ethical considerations and, 678
  goal setting, 627–628
  healthy versus distressed relationships and, 616–622, 617*f*
  mechanisms of change in the treatment of, 631
  older adult couples and, 456, 461–465
  older adults couples and, 467
  overview, 11, 615–616, 616*f*, 632
  practice of couple therapy for, 622–631, 625*t*
  process and technical aspects of couple therapy for, 628–631
  sexual problems and, 439
  sexuality and, 18
  See also Disability; Health factors; Physical health problems
Medications, 57, 156, 545, 622
Meditation practices, 108, 370
Memories
  accessing, 167–169
  "the magic question" and, 210–211
  mentalization-based couple therapy and, 176
  object relations couple therapy and, 166–169, 172, 173
  splitting and, 158, 166–167
Memory functioning, 24*t*, 456, 464–465
Menopause, 456
Mental health
  acceptance and commitment couple therapy and, 112
  aggression and, 394
  alcohol behavioral couple therapy and, 560, 565
  applicability and empirical support for, 261–262
  approaches to couple therapy and, 16
  cognitive-behavioral conjoint therapy for PTSD, 545
  cognitive-behavioral couple therapy and, 69–70, 73
  ethical considerations and, 678
  intergenerational couple therapy and, 217–218
  mentalization-based therapy (MBT) and, 175
  narrative couple therapy and, 243
  object relations couple therapy and, 151–152, 156
  overview, 3
  See also Anxiety; Depression; Individual problems; Psychopathology
Mentalization Questionnaire, 34, 181

Mentalization-based couple therapy (MBT-CO)
  acceptance and, 17
  applicability and empirical support for, 188
  assessment and treatment planning and, 181
  case illustration, 188–196
  curative factors/mechanisms of change in, 186–188
  evolution of couple therapies, 8
  goal setting, 181–182
  healthy versus distressed relationships and, 178–179
  individual disorders and, 16
  interventions in, 184–186
  overview, 175–178, 196
  practice of, 179–186, 180*t*, 181*t*
  role of therapist and, 180–181, 182–184
  structure of, 179–180, 180*t*, 181*t*
Mentalization-based therapy (MBT), 175–178
Mentalizing
  chain analysis and, 185
  divorce therapy and, 483
  intergenerational couple therapy and, 209
  mentalization-based couple therapy and, 186–187
  overview, 7, 175–176
  role of therapist and, 180–181, 184
Mental-state language, 188
Meta-emotion, 366–367, 376–378
Meta-Emotion Interview, 363, 377
Metaphors, 110, 111, 112–113, 228, 347
Military couples, 650, 663
Mindfulness, 7, 14, 354, 482–483
Minority stress model, 513, 522–523
Miracle questions, 210–211, 219–220, 257
Mixed-agenda couples, 349. *See also* Goals of treatment
Montreal Cognitive Assessment (MoCA), 34, 464
Mood disorders. *See* Bipolar disorder; Depression
Motivation, 160–161, 303, 560, 562, 567
Motivational interviewing, 481
Motivational reframing, 558–559
Multicultural competence, 694–696
Multicultural perspectives, 8, 261–262, 540. *See also* Cultural factors
Multidimensional Emotional Abuse Scale, 112
Multidimensional Measure of Emotional Abuse (MMEA), 397
Multidimensional Psychological Flexibility Inventory (MPFI), 34, 112
Multidimensional relational framework, 106–108
Multidirected partiality, 204, 205, 206, 214, 218–219, 351
Multiple relationships, 690–691
Mutual attunement, 270, 272, 272*f*
Mutual empowerment, 208–209
Mutual vulnerability, 270, 272, 272*f*
Mutual-help groups, 563, 567
Mutuality, 270, 272, 272*f*, 276–277, 279*f*, 283–284, 368

N

Namecalling, 370, 584
Naming problems and projects, 235, 274, 276
Narcissism, 151, 155
Narrative approaches
  applicability and empirical support for, 242–243
  assessment and treatment planning and, 231–232
  case illustration, 243–247
  divorce therapy and, 482
  evolution of couple therapies, 8
  goal setting, 232–233
  healthy versus distressed relationships and, 228–229
  intergenerational couple therapy and, 213–214
  mechanisms of change in, 242
  overview, 227–228, 247
  practice of, 229–242
  process and technical aspects of, 233–242
  role of therapist and, 10, 230–231
  solution-focused couple therapy and, 256–259
  structure of, 229–230
Narrative systemic model, 271*t*
National origin, 268. *See also* Identity-related factors
Needs of the individual. *See* Individual needs
Negative affect, 55–56, 344, 367–371
Negativity, 29–30, 111, 203, 216
Negotiation, 7, 481
Neuroscience, 5–6, 200, 201, 366, 373–374, 435
Nonbinary people, 513. *See also* Gender; Queer couples
Nonmonogamy, consensual, 519–522, 525–526
Nonverbal communication behaviors, 31, 83, 371–372, 397
Norms, 34–36, 474–475
“Not knowing” position of therapist, 182–183, 275
Novelty, 342, 352
Nuclear family level, 23–26, 24*t*–25*t*
Numbing, 536–537

O

Object relations couple therapy
  applicability and empirical support for, 173
  assessment and treatment planning and, 157–160
  case illustration, 161–163, 164–165, 166, 167–171
  evolution of couple therapies, 8
  goal setting, 160–161
  healthy versus distressed relationships and, 154–155
  mechanisms of change in, 172
  overview, 151–154, 173
  practice of, 155–172
  process and technical aspects of, 161–172
  role of therapist and, 10, 156–157
  structure of, 155–156
Observation in assessment, 22, 26, 30–31, 38–40, 60, 364. *See also* Assessment
Obsessive–compulsive disorder (OCD)
  accommodation and, 579, 587
  cognitive-behavioral couple therapy and, 69–70, 73

Obsessive–compulsive disorder (OCD) (*continued*)
  couple therapy for anxiety and, 577
  depression or anxiety and, 582, 588–589
  overview, 576
  See also Anxiety disorders
Older adult couples
  applicability and empirical support for treatment with, 469
  assessment and treatment planning and, 34, 468–469
  core understandings about, 455–466
  differences across approaches and, 12
  overview, 454–455, 455*f*, 469
  practice of couple therapy with, 466–469
  role of therapist and, 467–468
  sexuality and, 18
  stepfamily couples and, 507–508
  See also Contextual adult lifespan theory for adapting psychotherapy (CALTAP)
Online programs, 642–643, 646, 653, 664–671, 692–693. *See also* Remote therapy; Telehealth
Oppositional defiant disorder (ODD), 596, 606. *See also* Disruptive behavior disorders parenting concerns
Oppression, 56, 269, 274, 398
Oral History Interview, 363, 364, 378, 380–381
OurRelationship program
  applicability and empirical support for, 97
  future directions and, 671–672
  integration of into couple therapy, 665, 666, 667–670
  overview, 101, 642–643, 653
  See also Integrative behavioral couple therapy (IBCT)
Outcomes from couple therapy
  acceptance and commitment couple therapy and, 105–106
  aggression and, 405
  alcohol behavioral couple therapy and, 568
  cognitive-behavioral conjoint therapy for PTSD, 542
  emotionally focused couple therapy and, 140–141, 142
  maintaining gains, 18–19
  overview, 4
  sex therapy and, 448
Out-of-session assignments. *See* Homework assignments

P

Pain and pain management, 119, 616. *See also* Medical issues
Pain with intercourse, 434, 435. *See also* Sexual problems
Panic disorder, 588–589. *See also* Anxiety disorders
Pansexuality, 522–523. *See also* Queer couples
Parent Development Interview—Reflective Functioning Scale, 181
Parental ADHD, 602, 603, 606–607. *See also* Attention-deficit/hyperactivity disorder (ADHD)
Parental psychopathology, 473–474
Parentification, 214
Parenting concerns
  adult ADHD and, 600
  alcohol use and, 556
  approaches to couple therapy and, 16
  assessment and, 34
  cognitive-behavioral conjoint therapy for PTSD, 546
  core understandings about, 597–598
  divorce therapy and, 473–475, 477, 479, 480, 483–484, 485
  Gottman method and, 363
  mechanisms of change and, 606
  medical issues and, 617
  mentalization-based couple therapy and, 188
  overview, 595–596
  queer couples and, 518–519
  relationship education programs and, 649
  stepfamily couples and, 496–500, 499*f*, 501–502, 505, 506, 507
  telemental health and, 659–660
  transitions regarding parenting roles, 363
  See also ADHD parenting concerns; Behavioral parent training (BPT); Children; Co-parenting; Custody arrangements; Disruptive behavior disorders parenting concerns; Stepfamily couples
Parenting factors, 299–300
Parents, 206, 216–217
Parents and Children Together (PACT) study, 652
Parkinson's disease, 464
Partner accommodation, 535, 545. *See also* Accommodation
Partner aggression. *See* Aggression; Intimate partner violence (IPV)
Partner-assisted interventions, 16, 69, 70
Past, role of
  acceptance and commitment couple therapy and, 109
  differences across approaches and, 11
  Gottman method and, 369
  integrative systemic therapy and, 327
  intergenerational therapy and, 199–200
  object relations couple therapy and, 165–166
  overview, 14–15
  therapeutic palette integrative approach and, 344
  See also Temporal framework
Patriarchy, 232, 392
Patterns of interaction
  aggression and, 399–400
  cognitive-behavioral conjoint therapy for PTSD, 539
  common factors in couple and family therapy and, 307
  DEEP analysis and, 84–85
  depression or anxiety and, 584
  emotionally focused couple therapy and, 136–138
  Gottman method and, 369–370
  integrative systemic therapy and, 325
  intergenerational couple therapy and, 207, 209, 215, 217

  "the magic question" and, 211
  therapeutic palette integrative approach and, 354
  unified detachment and, 91–92
  See also Communication patterns and skills; Relationship functioning; Relationship patterns
Perceived criticism, 578–579, 584, 629. *See also* Criticism
Personality disorders, 394, 417, 557
Perspective, 183, 185, 188, 204, 209
Physical aggression. *See* Aggression
Physical Aggression Couples Treatment (PACT) program, 392, 405–406
Physical frailty, 462–464, 467
Physical health problems, 3, 69–70, 73, 112, 139. *See also* Health factors; Medical issues
Physiology, 364, 367, 370, 435, 495
PICK program, 644
Planning process, 327–329, 328*f*
Playfulness, 187–188
PLISSIT model, 439, 440
Polyamory, 435, 438, 519–522. *See also* Queer couples
Positioning, 239–240, 279–281, 279*f*
Positive affect, 55–56, 344, 371–376
Positive enactments, 352
Positive regard, 261, 305, 404
Poststructuralism, 227, 228
Posttraumatic growth, 537–538
Posttraumatic stress disorder (PTSD)
  acceptance and commitment couple therapy and, 119
  aggression and, 394
  alcohol behavioral couple therapy and, 569
  assessment and, 33–34
  case illustration, 546–551
  cognitive-behavioral couple therapy and, 69–70, 73
  core understandings about, 534–536
  digital couple interventions and, 667
  emotionally focused couple therapy and, 140
  infidelity and, 413, 426
  object relations couple therapy and, 156
  overview, 9, 533–534, 551
  telemental health and, 658
  See also Anxiety disorders; Cognitive-behavioral conjoint therapy for PTSD (CBCT PTSD); Trauma
Poverty, 13, 201, 566, 616–617, 649. *See also* Financial factors; Socioeconomic status
Power
  acceptance and commitment couple therapy and, 107–108, 115–116
  aggression and, 392, 394, 398, 403
  assessment and, 31
  intergenerational therapy and, 201, 205–207, 217, 230–234
  narrative couple therapy and, 228, 232, 234
  object relations couple therapy and, 151–152
  polyamory and, 521
  socioculturally attuned couple therapy and, 269, 270, 273, 274, 276–277, 279, 279*f*, 280–283, 285
  socio-emotional relationship therapy (SERT) and, 268
  therapeutic palette integrative approach and, 343
Power of Two program, 670
Power Over imbalances, 201, 212, 217, 230–234
Power To, 201, 212, 217
Power With, 201, 212, 217
Practice, 279, 279*f*, 283–284, 353–354, 539, 604, 661. *See also* Homework assignments
Prejudice, 139, 566
Premarital, Interpersonal, Choices and Knowledge (PICK) a Partner program, 644
Premarital therapy, 639, 648–649. *See also* Relationship education
PREPARE/ENRICH program, 640, 641–642
Present, role of, 14–15, 109, 112, 327–328, 344. *See also* Temporal framework
Present-focused therapy, 133–134
Presenting problems
  acceptance and commitment couple therapy and, 110
  assessment and, 28–29, 59
  cognitive-behavioral conjoint therapy for PTSD, 546
  common factors in couple and family therapy and, 307
  contextual adult lifespan theory for adapting psychotherapy (CALTAP) and, 455*f*
  differences across approaches and, 11
  integrative behavioral couple therapy and, 87
  integrative systemic therapy and, 320–321, 323
  listen–select–build process and, 252
  object relations couple therapy and, 161–162
  older adult couples and, 457, 466–467, 469
  sex therapy and, 441, 448
  therapeutic palette integrative approach and, 348
Prevention and Relationship Education Program (PREP)
  challenges when providing, 648
  integration into traditional therapy and, 646
  online version of, 642, 643, 653, 665, 666
  overview, 640–641
  Within My Reach program, 643–644
  Within Our Reach program, 641
Prevention programs, 55, 487. *See also* Distressed relationships; Relationship education
Privacy, 658–659, 681–684. *See also* Confidentiality
Problem Areas Questionnaire, 86*t*, 87, 88
Problem solving conversations. *See* Decision-making or problem-solving conversations

Problem-centered perspectives, 327–328, 331*t*
Problem-solving skills and training
  ADHD and disruptive behavior disorders parenting concerns and, 604, 605, 606
  aggression and, 392, 393, 395, 400, 402, 403, 404
  alcohol behavioral couple therapy and, 557, 564
  assessment and, 31
  cognitive-behavioral conjoint therapy for PTSD, 537
  depression or anxiety and, 579, 584–585, 586
  divorce therapy and, 481
  Gottman method and, 371, 377–378
  infidelity and, 420, 423
  integrative behavioral couple therapy and, 83, 94
  integrative systemic therapy and, 320–322, 321*f*, 322*f*
  therapeutic palette integrative approach and, 352
Projective identifications, 156–157, 159, 172
Protection, 618–619
Psychoanalytic approaches, 6, 8, 11–15
Psychoeducation
  ADHD and disruptive behavior disorders parenting concerns and, 604, 605, 606
  aggression and, 392, 393, 394, 395, 401, 402–403, 404
  cognitive-behavioral conjoint therapy for PTSD, 536
  cognitive-behavioral couple therapy and, 57–58, 67, 70
  couple therapy for anxiety and, 577
  depression or anxiety and, 585–586
  divorce therapy and, 477–478, 480–481, 487
  integrative systemic therapy and, 323, 331*t*
  medical issues and, 631
  mentalization-based couple therapy and, 179
  object relations couple therapy and, 172
  older adults couples and, 469
  overview, 7
  parenting challenges within stepfamilies and, 499
  sex therapy and, 438–440, 447
  stepfamily couples and, 493, 495, 497, 499, 500–501, 502, 504
  technology use and, 16
  transitioning from individual to couple therapy and, 685–686
  See also Relationship education
Psychological flexibility, 104, 105, 106, 110, 118–119, 122
Psychology Interjurisdictional Compact (PSYPACT), 693
Psychopathology
  aggression and, 394, 404
  alcohol behavioral couple therapy and, 565
  cognitive-behavioral conjoint therapy for PTSD, 545
  cognitive-behavioral couple therapy and, 69–70
  divorce and, 473–474
  infidelity and, 417, 425
  intergenerational couple therapy and, 217–218
  object relations couple therapy and, 156
  See also Mental health
Psychosocial functioning, 539–540, 560, 616–617. *See also* Histories
Psychotic disorders, 175, 394
PTSD Checklist for DSM-5 (PCL-5), 540
Put-downs, 370, 584

Q
Quality of Marriage Index, 112
Quality of relationship domains framework (QRDF), 106–108, 115
Queer couples
  approaches to couple therapy and, 17
  case illustration, 525–528
  cognitive-behavioral couple therapy and, 68
  cohort differences and, 458–459
  core understandings about, 516–525
  family structure diversity and, 518–519
  gender role socialization and, 516–518
  inclusive language and, 512–513
  intersectional framework and, 513–516
  older adult couples and, 458–459
  overview, 512–516, 528
  relationship education programs and, 648, 649–650
  role of therapist and, 524–525
  sex therapy and, 438
  stepfamily couples and, 505–506
  therapist competence and, 694–696
  See also Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples; Same-gender couples
Questioning
  cognitive-behavioral conjoint therapy for PTSD, 539
  deconstructive questioning, 233–234, 242
  integrative systemic therapy and, 324
  medical issues and, 625–626, 625*t*
  sex therapy and, 441
  solution-focused couple therapy and, 256–259
Questionnaires in assessment. *See* Assessment; Self-report methods

R
Race
  aggression and, 394, 398
  alcohol behavioral couple therapy and, 566
  cognitive-behavioral conjoint therapy for PTSD, 540
  emotionally focused couple therapy and, 139
  intersectional framework and, 513–516
  narrative couple therapy and, 234
  object relations couple therapy and, 154
  relationship education and, 640, 650–651
  socioculturally attuned couple therapy and, 268

  therapeutic palette integrative approach and, 351
  therapist competence and, 694–696
  See also Identity-related factors
Racism
  aggression and, 394
  cognitive-behavioral conjoint therapy for PTSD, 540
  intergenerational therapy and, 201
  levels of intervention and, 13
  medical issues and, 620
  queer couples and, 513
  socioculturally attuned couple therapy and, 268
Reactivity
  empathic joining and, 90
  healthy versus distressed relationships and, 203
  intergenerational couple therapy and, 209, 213, 214
  interventions focusing on in CBCT, 66–67
  medical issues and, 630–631
  mentalization-based couple therapy and, 184–185
  object relations couple therapy and, 151–152, 159
  stepfamily couples and, 504
  tolerance building and, 93–94
  See also Expression of emotions
Reality construction, 128, 158, 204, 209
Reassurance seeking, 578, 579
Records, 479–480, 484–486, 684. *See also* Confidentiality
Reengagement, 146–147. *See also* Engagement
Referrals from couple therapy, 57, 398, 646–647, 665, 685–687
Reflection, 131–132, 134, 204–205
Reframing, 7, 135
Regulatory considerations, 663, 670–671
Relapse prevention, 563, 564, 567, 585
RELATE online relationship inventory, 670
Relational ethics, 207, 209
Relational frame, 7, 201, 204, 240–241
Relational impact awareness, 187
Relational intersectionality, 513–516. *See also* Intersectional lens
Relational–intergenerational approach, 201
Relationship Checkup Scales, 381
Relationship Checkup Study, 382–383
Relationship Coach videos, 367, 381
Relationship education
  applicability and empirical support for, 648–653
  challenges when providing, 648
  overview, 17, 639–640, 653
  programs providing, 640–644
  providing, 644–648
  technology use and, 16
  See also Psychoeducation
Relationship functioning
  ADHD and disruptive behavior disorders parenting concerns and, 603
  aggression and, 393, 397, 404
  alcohol behavioral couple therapy and, 560–561, 564–565, 568
  assessment and, 23–26, 32–33, 134
  behavioral parent training (BPT) and, 606
  cognitive-behavioral conjoint therapy for PTSD, 536, 545
  cognitive-behavioral couple therapy and, 54–56, 60
  depression or anxiety and, 577–578, 588
  emotionally focused couple therapy and, 130–131
  Gottman method and, 362
  infidelity and, 413
  maintaining gains, 18–19
  medical issues and, 620–622, 626
  older adult couples and, 457–458
  overview, 10, 12, 13
  predicting with the Gottman method, 363–364, 381
  queer couples and, 513, 517
  sex therapy and, 443*t*
  See also Healthy vs. distressed relationships
Relationship history. *See* Histories
Relationship patterns
  aggression and, 399–400
  common factors in couple and family therapy and, 307
  depression or anxiety and, 584
  emotionally focused couple therapy and, 128, 137–138
  integrative behavioral couple therapy and, 79, 81
  medical issues and, 620–622
  object relations couple therapy and, 172
  overview, 7
  relationship education programs and, 643–644
  sex therapy and, 447
  socioculturally attuned couple therapy and, 269
  therapeutic palette integrative approach and, 350
  See also Patterns of interaction; Relationship functioning
Relationship Quality Interview (RQI), 112
Relaxation, 370, 402
Religion
  cognitive-behavioral conjoint therapy for PTSD, 540
  healthy versus distressed relationships and, 55
  infidelity and, 415, 419
  integrative systemic therapy and, 327
  intersectional framework and, 514
  narrative couple therapy and, 234
  object relations couple therapy and, 154, 158
  relationship education programs and, 639, 649
  socioculturally attuned couple therapy and, 268
  See also Identity-related factors
Remarriage, 454. *See also* Divorce; Stepfamily couples
Remote therapy
  aggression and, 396–397
  digital couple interventions, 664–671

Remote therapy (*continued*)
  Gottman method and, 381
  medical issues and, 622
  older adults couples and, 467
  overview, 15–16
  relationship education programs and, 642–643
  sex therapy and, 448
  See also Online programs; Technology; Telemental health (TMH)
Repair, 203, 207, 215–216, 393
Resentment, 90, 208, 213, 629
Resilience, 128, 201
Resistance
  acceptance and commitment couple therapy and, 111
  aggression and, 403
  alcohol behavioral couple therapy and, 567
  Gottman method and, 380
  intergenerational couple therapy and, 205–206, 217
  object relations couple therapy and, 160–161
  sex therapy and, 447–448
  stepfamily couples and, 497
Respect, 107–108, 115–116, 205, 211, 370, 374
Responsibility
  depression or anxiety and, 586
  Gottman method and, 369–370
  intergenerational couple therapy and, 204–205, 207, 208–209, 213, 215–216
Responsiveness
  emotionally focused couple therapy and, 130, 131
  Gottman method and, 365
  interventions focusing on in CBCT, 66–67
  mentalization-based couple therapy and, 184–185, 187
Retirement, 460–461. *See also* Older adult couples
Revised Conflict Tactics Scales (CTS2), 397, 560
Risk assessment, 61, 206–207, 217–218, 273, 687–688, 689
Risk factors, 70–71, 392, 393–394, 556–557, 597–598, 601
Rituals of connection, 378–379. *See also* Connection
Roles, 215, 473, 618–619
Roles of therapist. *See* Therapist
Romance, 342–343, 375
Routines, 495, 501, 578
Rules, 80, 117, 481–482
Rupture repair, 368, 403, 487

S

Safety
  aggression and, 404
  divorce therapy and, 486
  ethical considerations and, 687–688
  infidelity and, 414
  intergenerational couple therapy and, 206–207, 216
  queer couples and, 513
  safety behaviors, 535
  stepfamily couples and, 503
  See also Safety in relationships; Safety in sessions
Safety in relationships. *See also* Safety
  alcohol behavioral couple therapy and, 560
  cognitive-behavioral conjoint therapy for PTSD, 536, 541
  emotionally focused couple therapy and, 130
  ethical considerations and, 687–688
  relationship education programs and, 640–641
  safety planning, 398, 543
  telemental health and, 659
Safety in sessions
  aggression and, 395, 397, 403
  cognitive-behavioral conjoint therapy for PTSD, 543
  cognitive-behavioral couple therapy and, 67
  empathic joining and, 90–91
  integrative behavioral couple therapy and, 88–89
  intergenerational couple therapy and, 205
  mentalization-based couple therapy and, 182
  object relations couple therapy and, 156, 161, 173
  solution-focused couple therapy and, 259–260
  See also Safety
Same-gender couples
  aggression and, 392, 394
  alcohol behavioral couple therapy and, 566
  cognitive-behavioral couple therapy and, 56
  cohort differences and, 458–459
  emotionally focused couple therapy and, 138–139
  Gottman method and, 382–383
  infidelity and, 415
  object relations couple therapy and, 158
  older adult couples and, 458–459
  relationship education and, 639–640, 648, 649–650
  sex therapy and, 438
  stepfamily couples and, 505–506
  See also Queer couples
Savoring positive affect, 373–376. *See also* Positive affect
Schemas, 24*t*, 65, 414
Secrets, 134, 681–684
Secure attachment, 129, 130–131, 140, 188, 299–300. *See also* Attachment
Self-care, 94, 420, 421
Self-disclosure, 10, 13, 347, 624. *See also* Therapist
Self-esteem
  ADHD and disruptive behavior disorders parenting concerns and, 603
  depression or anxiety and, 580, 583
  Gottman method and, 380
  infidelity and, 421
  object relations couple therapy and, 153, 154, 159
  queer couples and, 513
  trans partners and, 523–524
Self-Management and Recovery Training (SMART® Recovery), 563, 567
Self-management planning, 563, 619–621, 632
Self-of-therapist issues, 396, 522
Self-protection, 203, 208–210
Self-report methods
  acceptance and commitment couple therapy and, 112
  ADHD and disruptive behavior disorders parenting concerns and, 601–602
  alcohol behavioral couple therapy and, 559–560

  case illustration, 40–43, 42*f*
  cognitive-behavioral conjoint therapy for PTSD, 540
  cognitive-behavioral couple therapy and, 60
  divorce and, 477
  emotionally focused couple therapy and, 134
  Gottman method and, 363, 364
  integrative behavioral couple therapy and, 86, 86*t*
  mentalization-based couple therapy and, 181
  overview, 31–34
  sex therapy and, 442
  telemental health and, 660
  See also Assessment
Self-responsibility, 204–205, 208–209
Self-soothing, 367, 370, 402
Sensate focus, 348, 444–446, 447, 673
Separation
  cognitive-behavioral conjoint therapy for PTSD, 545–546
  depression or anxiety and, 587
  ethical considerations and, 689–690
  infidelity and, 423–424
  integrative behavioral couple therapy and, 89–90
  older adults couples and, 468
  overview, 476
  psychoeducation and, 480–481
  telemental health and, 663
  See also Divorce
Separation distress, 129, 136
Sequences, 94, 320–321, 321*f*, 331*t*
Sex therapy
  applicability and empirical support for, 448–449
  assessment and treatment planning and, 440–442, 443*t*
  case illustration, 449–452
  mechanisms of change in, 447–448
  older adult couples and, 457
  overview, 434–436, 449–452
  practice of, 437–444, 443*t*
  process and technical aspects of, 444–447
  role of therapist and, 439–440
  structure of, 437–439
  See also Sexual problems
Sex-positive approach, 446–447
Sexual identity, 8, 540
Sexual infidelity. *See* Infidelity
Sexual minority couples, 68, 394. *See also* Queer couples
Sexual orientation
  aggression and, 398
  cognitive-behavioral conjoint therapy for PTSD, 545
  emotionally focused couple therapy and, 138–139
  intersectional framework and, 513–516
  levels of intervention and, 13
  narrative couple therapy and, 234
  object relations couple therapy and, 158
  overview, 8
  role of therapist and, 524–525
  socioculturally attuned couple therapy and, 268
  therapeutic palette integrative approach and, 351
  See also Identity-related factors; Queer couples
Sexual problems
  biopsychosocial model and, 443*t*
  case illustration, 449–452, 527–528
  core understandings about, 436–437
  medical issues and, 630
  older adult couples and, 456–457, 462, 463–464
  overview, 434–436, 449–452
  technology use and, 673
  trans partners and, 523–524, 527–528
  See also Sex therapy
Sexual relationship, 107, 115, 351, 375, 462, 463–464. *See also* Sexual problems
Sexuality, 17, 18, 138–139, 456–457. *See also* Identity-related factors
Shame, 205, 211, 421, 447, 504, 506
Shared meaning systems, 365, 378–379
Shared relational responsibility, 270, 272*f*, 273, 279*f*, 283–284
Sibling relationships, 497
Skills-based interventions and training
  acceptance and commitment couple therapy and, 110
  ADHD and disruptive behavior disorders parenting concerns and, 604, 605
  aggression and, 395
  alcohol behavioral couple therapy and, 555, 557, 561–562, 573
  cognitive-behavioral conjoint therapy for PTSD, 539
  cognitive-behavioral couple therapy and, 63–64, 64*t*
  infidelity and, 414
  integrative behavioral couple therapy and, 83, 94
  integrative systemic therapy and, 323, 331*t*
  telemental health and, 661
  therapeutic palette integrative approach and, 352
  See also Communication skills training; Relationship education
Social anxiety disorder (SAD), 576, 578, 579, 589. *See also* Anxiety disorders
Social phobia, 578
Social systems
  alcohol behavioral couple therapy and, 560, 563
  assessment and, 23–26, 24*t*–25*t*
  healthy versus distressed relationships and, 55
  object relations couple therapy and, 154
  older adult couples and, 459–462
  sex therapy and, 443*t*
  social support, 579–580, 585, 619, 627–628, 631
  therapeutic palette integrative approach and, 351
Societal inequalities, 267, 268, 269–270
Sociocultural contexts
  cognitive-behavioral conjoint therapy for PTSD and, 540
  intergenerational couple therapy and, 201, 207

Sociocultural contexts (*continued*)
  narrative couple therapy and, 232
  sexual problems and, 435
  socioculturally attuned couple therapy and, 279, 279*f*, 280–281
  therapist competence and, 694–696
Socioculturally attuned couple therapy
  case illustration, 286–289
  cognitive-behavioral couple therapy and, 56
  evolution of couple therapies, 8
  overview, 17, 267–268, 289
  See also Socioculturally attuned family therapy (SCAFT); Socio-emotional relationship therapy (SERT)
Socioculturally attuned family therapy (SCAFT)
  applicability and empirical support for, 284–286
  assessment and treatment planning and, 275–278
  case illustration, 286–289
  healthy versus distressed relationships and, 269–273, 271*f*, 272*f*
  mechanisms of change in, 284
  overview, 267–268, 289
  practice of, 273–284, 279*f*
  process and technical aspects of, 279–284, 279*f*
  role of therapist and, 273–275, 278
  structure of, 273
Socioeconomic status, 154, 158, 514, 566. *See also* Financial factors; Poverty
Socio-emotional relationship therapy (SERT)
  applicability and empirical support for, 284–286
  assessment and treatment planning and, 275–278
  case illustration, 286–289
  mechanisms of change in, 284
  overview, 267, 268, 289
  process and technical aspects of, 279–284, 279*f*
  role of therapist and, 275
Softening, 7, 132–133, 137–138
Solution-focused approaches, 15, 271*t*, 303, 481
Solution-focused brief therapy (SFBT), 250–252, 392–393. *See also* Solution-focused couple therapy
Solution-focused couple therapy
  aggression and, 392
  applicability and empirical support for, 261–262
  assessment and goal setting and, 254–255
  case illustration, 262–264
  evolution of couple therapies, 8
  mechanisms of change in, 261
  overview, 15, 250–252, 264–265
  practice of, 252–260
  process and technical aspects of, 253–259
  role of therapist and, 253–254, 260
  structure of, 252–253
  termination and, 260
  See also Solution-focused brief therapy (SFBT)
Soothing, 370, 371, 402
Speaker–Listener Method, 370, 643–644, 646
Specific Affect Coding System (SPAFF), 363, 364, 365, 367, 381
Spirituality, 201, 327. *See also* Religion
Split alliances, 308–309, 330–331. *See also* Therapeutic alliance/relationship
Splitting, 152, 154–155, 156–157, 158, 160, 166–167, 173
Standards for relationship functioning, 23, 66, 401, 414
Stepfamily couples
  approaches to couple therapy and, 17
  assessment and, 503–504
  building a new family culture challenge, 500–501
  case illustration, 508–509
  challenges faced by, 493, 494–502, 503
  children's struggles within, 496–498
  core understandings about, 492–493
  differences across approaches and, 12
  empirical support for couple therapy with, 508
  exspouses and coparenting challenges, 501–502
  insider–outsider relationships, 494–496
  intersectionalities with, 504–508
  older adult couples and, 463, 466
  overview, 8, 492, 509
  parenting challenges within, 498–500, 499*f*
  practice of couple therapy with, 493–502, 499*f*
  process and technical aspects of working with, 502–504
  See also Co-parenting; Divorce
Stepsibling relationships, 497
Stonewalling patterns, 31, 202, 364, 370. *See also* Disengagement
Strengths and Difficulties Questionnaire, 602
Strengths of the relationship
  acceptance and commitment couple therapy and, 112
  aggression and, 392–393, 394, 398
  assessment and, 29, 258–259
  cognitive-behavioral conjoint therapy for PTSD, 540
  integrative behavioral couple therapy and, 88
  integrative systemic therapy and, 319, 331*t*
  intergenerational couple therapy and, 206
  medical issues and, 626
  overview, 7
  queer couples and, 517
  relationship education programs and, 641–642
  socioculturally attuned couple therapy and, 277–278
  therapeutic palette integrative approach and, 348
Stress
  ADHD and disruptive behavior disorders parenting concerns and, 600
  aggression and, 398
  depression or anxiety and, 578, 583–584

  divorce and, 474
  emotionally focused couple therapy and, 129
  Gottman method and, 364, 375, 377–378
  infidelity and, 419–420
  medical issues and, 620, 630–631
  mentalization-based couple therapy and, 176–177
  older adult couples and, 460
  queer couples and, 513
  relationship education programs and, 642
  sexual problems and, 435
  socioculturally attuned couple therapy and, 284–285
  therapeutic palette integrative approach and, 343–344
Stress-reducing conversation, 375, 377–378
Structural systemic models, 8, 23–26, 24*t*–25*t*, 271*t*, 347. *See also* Developmental factors
Structure of therapy process
  ADHD and disruptive behavior disorders parenting concerns and, 599–600
  alcohol behavioral couple therapy and, 557–558, 558*t*
  cognitive-behavioral conjoint therapy for PTSD, 536–538
  cognitive-behavioral couple therapy and, 56–57
  depression and anxiety and, 580
  emotionally focused couple therapy and, 131–132
  Gottman method and, 367
  infidelity and, 416–417
  integrative behavioral couple therapy and, 82–83
  integrative systemic therapy and, 319–322, 321*f*, 322*f*
  intergenerational couple therapy and, 204–205
  medical issues and, 622–624
  mentalization-based couple therapy and, 179–180, 180*t*, 181*t*
  narrative couple therapy and, 229–230
  object relations couple therapy and, 155–156
  older adults couples and, 466–467
  partner aggression and, 394–395
  sex therapy and, 437–439
  socioculturally attuned couple therapy and, 273
  solution-focused couple therapy and, 252–253
  therapeutic palette integrative approach and, 344–346
Structured Clinical Interview for DSM-5 Disorders, 560
Substance abuse
  aggression and, 394
  assessment and, 30
  cognitive-behavioral conjoint therapy for PTSD, 545
  emotionally focused couple therapy and, 141
  infidelity and, 420
  multiple drug use, 565
  object relations couple therapy and, 157–158
  sex therapy and, 444
  See also Addiction; Alcohol behavioral couple therapy (ABCT); Alcohol use; Substance use disorders (SUDs)
Substance use disorders (SUDs)
  alcohol behavioral couple therapy and, 554
  cognitive-behavioral couple therapy and, 70, 73
  mentalization-based therapy (MBT) and, 175
  multiple drug use, 565
  overview, 3
  See also Addiction; Alcohol use disorder (AUD); Substance abuse
Suicidality, 30, 34, 420, 545, 690
Support
  acceptance and commitment couple therapy and, 107, 115
  aggression and, 395, 404
  assessment and, 31
  Circle of Care and, 270, 272–273, 272*f*
  depression or anxiety and, 585
  Gottman method and, 379
  infidelity and, 424
  medical issues and, 619, 627–628, 631
  mentalization-based couple therapy and, 184–185
Support groups, 462–463, 563, 567, 631
Survival strategies
  case illustration, 218–219, 219*f*
  intergenerational therapy and, 201, 202–203, 205, 207, 209–210
  "the magic question" and, 211
Symptom Checklist-90—Revised (SCL90R), 33–34
Systemic approaches
  alcohol behavioral couple therapy and, 554
  common factors in couple and family therapy and, 307, 686–687
  differences across approaches and, 11–15
  emotionally focused couple therapy and, 127, 128–129
  integrative systemic therapy and, 319
  medical issues and, 615–617, 616*f*
  older adults couples and, 467
  overview, 9, 13, 14
  sex therapy and, 448
  socioculturally attuned couple therapy and, 270, 271*t*, 273
  stepfamily couples and, 503
Systemic Therapy Inventory of Change (STIC), 37

T
Teacher Report Form, 602
Team-based care environments, 438, 462, 623, 645
Techniques, 7, 9. *See also* Interventions; Therapeutic strategies; *individual strategies and techniques*
Technology
  alcohol behavioral couple therapy and, 562–563
  cutting-edge technology and its applications to couples, 673
  devices used for telemental health and, 663
  digital couple interventions, 664–671
  future directions, 671–673
  legal and regulatory considerations in, 663
  overview, 15–16, 656, 673
  See also Online programs; Remote therapy; Telehealth

- Telehealth
  - aggression and, 396–397
  - differences across approaches and, 12
  - digital couple interventions, 664–671
  - ethical considerations and, 692–693
  - future directions, 671–673
  - medical issues and, 622
  - older adults couples and, 467
  - overview, 15–16, 656, 673
  - relationship education programs and, 642–643
  - sex therapy and, 448
  - *See also* Online programs; Remote therapy; Technology; Telemental health (TMH)
- Telemental health (TMH)
  - digital couple interventions, 664–671
  - ethical considerations and, 692–693
  - future directions, 671–673
  - legal and regulatory considerations in, 663
  - overview, 656–663, 673
  - *See also* Remote therapy; Telehealth
- Temporal framework
  - acceptance and commitment couple therapy and, 109
  - integrative systemic therapy and, 320, 331*t*
  - overview, 14–15, 330
  - therapeutic palette integrative approach and, 344, 350
  - *See also* Future, role of; Past, role of; Present, role of; Time frame (present, past, or future)
- Termination
  - aggression and, 404
  - alcohol behavioral couple therapy and, 567
  - cognitive-behavioral conjoint therapy for PTSD, 542
  - depression or anxiety and, 585
  - emotionally focused couple therapy and, 136–137
  - integrative behavioral couple therapy and, 82
  - integrative systemic therapy and, 331–332
  - intergenerational couple therapy and, 208
  - maintaining gains, 19
  - medical issues and, 631
  - object relations couple therapy and, 171–172
  - overview, 15
  - sex therapy and, 446
  - solution-focused couple therapy and, 260
  - *See also* Goals of treatment
- Therapeutic alliance/relationship
  - acceptance and commitment couple therapy and, 110–111
  - ADHD and disruptive behavior disorders parenting concerns and, 599
  - aggression and, 396, 403, 404
  - alcohol behavioral couple therapy and, 558–559, 573
  - boundary issues and, 690–692
  - change and, 352–353
  - cognitive-behavioral couple therapy and, 58
  - common factors and, 296
  - common factors in couple and family therapy and, 301–302, 305–306, 307, 308–309, 311
  - contextual adult lifespan theory for adapting psychotherapy (CALTAP) and, 455*f*
  - divorce therapy and, 477, 480, 486–487
  - emotionally focused couple therapy and, 127, 131, 133
  - infidelity and, 417–418
  - integrative systemic therapy and, 323, 330–331, 331*t*
  - intergenerational couple therapy and, 205, 217
  - overview, 7, 10
  - socioculturally attuned couple therapy and, 274–275
  - solution-focused couple therapy and, 254
  - stepfamily couples and, 495–496
  - telehealth and, 660–661, 671
  - therapeutic palette integrative approach and, 341–342, 344–345, 352–353, 359
  - transitions to and from couple therapy and, 685–686
- Therapeutic conversations
  - infidelity and, 422
  - integrative systemic therapy and, 322, 324
  - narrative couple therapy and, 231
  - solution-focused couple therapy and, 256, 261, 265
- Therapeutic palette integrative approach (TP)
  - applicability and empirical support for, 354
  - assessment and treatment planning and, 348–349
  - case illustration, 354–359
  - goal setting, 349
  - healthy versus distressed relationships and, 342–344
  - mechanisms of change in, 347, 352–354
  - overview, 339–342, 359
  - practice of, 344–352
  - process and technical aspects of, 349–352
  - role of therapist and, 341–342, 346–348, 352–353
  - structure of, 344–346
- Therapeutic strategies, 7, 9, 114–118. *See also* Interventions; Techniques; *individual strategies and techniques*
- Therapist
  - acceptance and commitment couple therapy and, 110–111
  - ADHD and disruptive behavior disorders parenting concerns and, 598–599, 600–601
  - aggression and, 395–396
  - alcohol behavioral couple therapy and, 558–559, 566–567, 573
  - boundary issues and, 690–692
  - cognitive-behavioral conjoint therapy for PTSD, 538–539, 542–543
  - cognitive-behavioral couple therapy and, 57–58, 66, 67, 68–69, 71
  - collaborative therapists, 17
  - common factors in couple and family therapy and, 303, 304–307, 311
  - competence of, 68–69, 693–696
  - countertransference and, 159–160

  cultural competence and, 68–69
  depression or anxiety and, 580
  differences across approaches and, 11, 12–13
  discomfort with exchanges in sessions, 29–30
  divorce and, 477–478
  divorce therapy and, 480
  emotionally focused couple therapy and, 128, 133, 142–143
  ethical considerations and, 10–11, 681, 693–696
  infidelity and, 417–418, 425
  integrative behavioral couple therapy and, 83–84, 85–86
  integrative systemic therapy and, 322–323
  intergenerational couple therapy and, 205–206
  intersectional framework and, 515–516
  mentalization-based couple therapy and, 180–181, 182–184
  narrative couple therapy and, 230–231
  object relations couple therapy and, 156–157, 159–160, 163
  older adults couples and, 467–468
  queer couples and, 515–516, 522, 524–525, 528
  role of, 10, 12–13, 27
  sex therapy and, 439–440
  sexuality and, 18
  socioculturally attuned couple therapy and, 273–275, 278
  solution-focused couple therapy and, 253–254, 260
  telehealth and, 660–661, 672–673
  therapeutic palette integrative approach and, 341–342, 346–348
  See also Therapeutic alliance/relationship
Thoughts
  acceptance and commitment couple therapy and, 111
  aggression and, 392, 395, 401
  assessment and, 24*t*
  cognitive-behavioral couple therapy and, 55–56, 65–66
  integrative systemic therapy and, 320, 326–327
  mentalization-based couple therapy and, 178
  See also Cognitions
Time frame (present, past, or future), 11, 14–15, 320, 341–342, 344
Timeline Followback (TLFB), 397, 560
Time-out intervention, 400, 402, 420, 421, 482, 648
Tolerance, 80, 93–94, 100–101, 169–171, 183, 204
Training, 13, 142–143, 644, 693–696. *See also* Therapist
Trans communities, 438, 512–513, 516–517, 523–524, 527–528. *See also* Lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples; Queer couples
Transitions
  assessment and goal setting and, 133–134
  divorce therapy and, 474, 483, 486–487
  Gottman method and, 363
  healthy versus distressed relationships, 55
  medical issues and, 618–620, 632
  older adult couples and, 456–457, 460–461
  therapeutic palette integrative approach and, 342
Transparency, 416–417, 686
Trauma
  assessment and, 30
  emotionally focused couple therapy and, 138–139, 140
  infidelity and, 413–414, 416
  intergenerational therapy and, 201, 207, 214
  intergenerational transmission of, 199
  mentalization-based therapy (MBT) and, 175
  object relations couple therapy and, 173
  older adult couples and, 465
  sexual problems and, 435
  stepfamily couples and, 505–506
  See also Posttraumatic stress disorder (PTSD)
Trauma-focused cognitive-behavioral therapies, 533–534
Treatment goals. *See* Goals of treatment
Treatment planning
  acceptance and commitment couple therapy and, 111–114, 113*f*
  ADHD and disruptive behavior disorders parenting concerns and, 601–603
  aggression and, 396–398
  alcohol behavioral couple therapy and, 559–561, 566
  cognitive-behavioral conjoint therapy for PTSD, 539–541
  cognitive-behavioral couple therapy and, 59, 62
  depression or anxiety and, 580–582
  infidelity and, 418–420
  integrative behavioral couple therapy and, 84–89, 86*t*
  integrative systemic therapy and, 323–324
  intergenerational couple therapy and, 206–207
  medical issues and, 625–627, 625*t*
  mentalization-based couple therapy and, 181
  narrative couple therapy and, 231–232
  object relations couple therapy and, 157–160
  older adults couples and, 468–469
  sex therapy and, 440–442, 443*t*
  socioculturally attuned couple therapy and, 275–278
  therapeutic palette integrative approach and, 348–349
Triangulation, 200
Triggers, 202–203, 422, 500, 560–561
Trust
  acceptance and commitment couple therapy and, 107
  aggression and, 395
  common factors in couple and family therapy and, 303
  confidentiality and private information and, 683–684
  emotionally focused couple therapy and, 130

Trust (*continued*)
  Gottman method and, 365
  infidelity and, 416–417
  intergenerational couple therapy and, 207
  medical issues and, 619–620
  mentalization-based couple therapy and, 180*t*
  object relations couple therapy and, 151
  older adult couples and, 462
  therapeutic palette integrative approach and, 343, 353
  trustworthiness, 187, 207, 216, 414

U
Understanding, 7, 184–185, 621, 668–669
Unified detachment, 90, 91–92, 94, 99–100. *See also* Detachment
Up-regulate positive affect, 371–372, 374–376

V
Validation
  common factors in couple and family therapy and, 308, 309
  emotional expression and, 67
  emotionally focused couple therapy and, 127, 131–132, 134
  Gottman method and, 371–372
  intergenerational couple therapy and, 205
  mentalization-based couple therapy and, 184–185
  object relations couple therapy and, 151, 171
  stepfamily couples and, 504
  therapeutic palette integrative approach and, 349
Validity, 34–36
Values
  acceptance and commitment couple therapy and, 108–109, 110, 112, 114–116
  assessment and, 23
  divorce and, 473, 477–478
  Gottman method and, 379
  intergenerational couple therapy and, 208
  narrative couple therapy and, 236
  object relations couple therapy and, 154
  socioculturally attuned couple therapy and, 269, 274, 276
Verbal communication, 31, 83, 371–372, 543. *See also* Communication patterns and skills
Victimization, 391–392. *See also* Aggression; Violence
Videoconferencing, 15–16, 82, 693. *See also* Remote therapy; Technology; Telehealth; Telemental health (TMH)
Violence
  acceptance and commitment couple therapy and, 119
  alcohol behavioral couple therapy and, 560, 565
  cognitive-behavioral conjoint therapy for PTSD, 541, 545–546
  divorce therapy and, 477, 486
  emotionally focused couple therapy and, 141
  ethical considerations and, 687–688, 689
  infidelity and, 417
  integrative behavioral couple therapy and, 88–89
  intergenerational couple therapy and, 205, 217–218
  narrative couple therapy and, 242–243
  object relations couple therapy and, 155–156, 158
  therapeutic palette integrative approach and, 343
  See also Aggression; Intimate partner violence (IPV)
Violent resistance. *See* Aggression
Virtual therapy. *See* Remote therapy; Technology; Telehealth
Visitation arrangements, 474–475, 484–485, 501–502. *See also* Custody arrangements; Divorce; Parenting concerns
Vulnerability
  aggression and, 403
  Circle of Care and, 270, 272, 272*f*
  divorce therapy and, 478
  emotionally focused couple therapy and, 133
  intergenerational therapy and, 201, 203
  "the magic question" and, 210–211
  socioculturally attuned couple therapy and, 279*f*, 281–283, 285–286
  speaking from, 210
  therapeutic palette integrative approach and, 344
Vulnerability cycle, 9, 202–203, 208–210, 219–-221, 219*f*

W
Wearable technology, 673
Web-based resources. *See* Digital couple interventions (DCIs); Remote therapy; Technology; Telehealth
Weekly Questionnaire, 86*t*, 88, 89, 92
Well-being, 129, 130, 151, 270
We-mode, 187, 342–343, 349, 502–503
Western societal norms, 269–270, 437. *See also* Cultural factors
Withdrawal
  aggression and, 399–400
  alcohol behavioral couple therapy and, 562
  assessment and, 30–31
  depression and, 578
  emotionally focused couple therapy and, 137–138
  integrative behavioral couple therapy and, 81
  medical issues and, 620
  telemental health and, 663
Within My Reach program, 643–644
Within Our Reach program, 641
Witnessing, 7, 239–240, 241–242, 480
Working models, 129, 380
Workshops, 639–640, 645, 646–647, 653